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A Clinical Adaptation of the Psychopathologies

D M. Baltzan, M.D., F.F.C.P. (C), F.A.C.P., Saskatoon, Sask.

Psychological medicine is a part of everyday diagnosis and treatment. Critical problems requiring expert opinion make a specialty of the practice. Psychopathological problems, independent of other sickness, form the basis of at least 30 per cent of all clinical material.[1] The incidence complicating other diseases is countless.

The psychopathologies therefore deserve the same attention in definition as the anaemias or nephritis for instance. There are in this connection reliable clinical signs and symptoms of psychopathological characteristics to guide in diagnosis; there are useful deductive methods; and there are established clinical entities. A distracting feature, and one which discourages interest, is an exuberant terminology employed to portray phenomena which are frequently plainer than they sound. Another is the numerous "schools of thought" which complicate what could be a reasonably sound understanding of the problems in a clinical sense. In spite of the drawbacks the disorders representing mental ill-health can be organized for clinical convenience in obedience with the basic principles of the subject matter. Under the existing circumstances this can be done only with some compromises.

In the beginning some of the broad phases of the subject have to be retold or defined anew for the sake of conformity.

1. The margin of normal conduct is not as clearly defined as is the dividing line of the conspicuous abnormalities. In respect to the wide range of normal behaviour account must be taken of numerous preconditioning factors, viz., heritage, customs, tradition, environment, education and religious beliefs. Also the properties of right and wrong do not have uniform global values. All of these are reasons why all persons cannot be treated alike. Because of the many conditioning factors people are different and within the limits of his sphere the individual may be Normal.

2. The intrinsic mental functions within the intricate organization of the collective designation known as the "mind" are disturbed in many ways. Manifestations of outright disturbances at this source are virtually mental sufferings or Psychopathies.

3. Irregularities or imbalances in the functions related to the widespread network of the involuntary autonomic part of the nervous system alter physiological performances of organs, systems of organs, or the organism as a whole. The end-results are literally functional disturbances with emotional reactions as by-products. This mechanism is influenced but not controlled by cortical activities and vice versa. Derangements of this nature are Psychosomatic Disorders.

4. Organic disease producing pathological nerve tissue changes are termed Neuropathies.

The second and third of these are the abnormalities which enter into the present discussion.

I. The Psychopathies

The causes given for most psychopathies (see definition) are not positively settled. In the majority of psychopathies the mental aberrations, expressed in terms of behaviour patterns, are broadly stated as psychogenic in origin. There is a smaller number of known organic causes; syphilis of the brain, cerebrovascular diseases and various intoxications. (They are described later in dealing with the Psychoses). The diagnosis in these cases may be stated in dual terms, stressing either the psychopathic or the neuropathic exhibits as, by comparison, dementia paralytica or cerebral syphilis. In all of them detection requires insight on the part of the examiner and at times only skilled psychiatric analysis reveals the situation.

In the routine appraisal of conduct in everyday relationship with patients it is not difficult to gain the impression, subject to further proof, that the behaviour reflects the mental performances as either (1) Normal—with generous allowances, (2) Borderline, (3) Abnormal, (4) Deranged or (5) Demented. Equivalent formal terms for the same divisions are applied below. The exceptions, the diversions less easy to detect offer great difficulties, and as in all other branches of medicine, keep the specialists busy to unravel the true natures. Omitting the first of these, the rest constitute the psychopathies.

(1) Psychoneuroses (Borderline Group)

A uniformly accepted name for the identification of a borderline behaviour group is needed. In present day usage, psychoneurosis is a literary waif. Psychoneurosis can be made to imply all that the many labels attempt to describe concerning a class of borderline individuals regarded by

psychiatrists as psychopathic reaction types. In groping for descriptive terms of the types within this group these phrases appear: neurotic personalities, psychopathic personalities, mentally unstable persons, and neurotics. The position of this type of persons wavers on the fringe of normalcy bordering the psychoses. The status of the group is "more a peculiarity of personality than an actual disorder." [2] Representatives of the group comprise clinical entities but do not form strictly pathological varieties. They are not possessed of a psychosis or a neurosis, as defined later, but rather of anomalous traits. The persons with psychoneuroses are tolerable people, even if they are irritating company. They are not totally enmeshed in their foibles. It is peculiar that their wish is almost invariably to find the explanation for their troubles and sensations in some responsible corporal affliction. Complete restoration among them is not uncommon. This borderline group, "the milder mental aberrations, constitute 90% of the private practice of psychiatry." [3]

The cause of the singular misconducts is a weakness in making proper adaptations to seemingly ordinary social requirements or surroundings. The fault rests primarily in the inherent "weakness." That which is responsible for the "weakness" is ground for the greatest controversies and searching opinions, none of which needs to distract the practising physician for all practical purposes. The patients' symptoms are outcries of the impacts with challenges that make of them misfits. It is relatively easy to recognize that the symptoms express some form of maladjustment. It is less easy to identify the precise factors inducing the disorganization. In the psychoneurotic the conflict is persistent. In well fortified persons extraordinary circumstances will induce similar symptoms. A dissimilarity in the psychoneurotic and the more normal individual is that the force of the conflict is much greater than the resistance in the latter, and the effect usually lasts only for the duration of the stress.

The danger in all psychoneuroses lies in the occasional one progressing to a more serious perhaps irrevocable stage. Well integrated personalities do not seek paths of least resistance with ultimate detriment. But, out of this class of mental instabilities spring enduring specific psychoneurotic instabilities in the form of chronic delinquencies, chronic alcoholism, drug addictions and criminal tendencies.

(2) Neuroses (Abnormal Group)

The next common group of patients to consider are characterized by both mental and physical signs. Hysterical paralysis and traumatic neurosis are specimens. This clinical group of psychopathies is distinctive because of its mon type, and because the uncovering of the pure strain offers a real test of skill. The anxiet avoiding an error in physical diagnosis o shadows the responsibility of an oversight in psychiatric field. The physical symptoms im organic disorders. The mental reactions of group of patients are to abnormal fears, to normal motivations and to abnormal compel urgers. The motivations differ from the un trollable emotional reactions which will be m tioned in discussing the psychosomatic disor

The physician's attention is attracted firs the exclusion of a reasonable organic basis. T patients are too often victims first of innumer physical and surgical corrective measures. of this class, in my experience, had thirteen gical operations and it need hardly be ampl by adding the first of these was less neces than the last. If the reaction is beyond the p of all reasonable allowances for a physical ment it is realized belatedly the position is chopathological. Even in the end the conce of a mental causation is made with some givings. This ambiguity is a common clinica perience. The combination arouses early curi and it should automatically offer a clue.

For identification, this group is named Neuroses. The different forms of neuroses lap. Clinically, suspicion is readily aroused establish the diagnosis is a matter of clos servation and keeping an open mind to the p bilities. The separate entities include the an and traumatic neuroses, hysteria, hypochon neurasthenia and obsessions, compulsions and bias. Standard text-books describe these oughly.

In the language of the psychiatrist, patients have only a part of their person disturbed with a good preservation of their tact with the world, have only a minor degr distortion of reality and have some insight, recognition of the fact that they are sick." [4]

(3) Psychoses (Deranged Group)

A more clear-cut group of psychopathie flect strictly mental distortions. The m up-rooting is paramount. Physical patho accompaniments are lacking and if they are ent they do not form a barrier in diagnosis. exception is a duplicity type, with both m and physical signs, referred to later. The disorders of the whole group are charact by exhibiting these essential changes: pro fluctuations in mood (unreasonable elation depressions); detachments from reality (sec ness of shut-in personalities); and incongrui thought or perception (flight of ideas, del and hallucinations). The result is "wrong

ing, "wrong" behaviour, and "wrong" thinking and interpretation, in corresponding order.

To these acute disturbances is applied the name Psychoses. The psychoses are compounded of these clinical entities: (1) manic depressive psychosis, (2) schizophrenia and dementia praecox, (3) hebephrenia and paranoia and (4) organic psychosis.

The psychiatric definition described by example is as follows: "a psychotic patient is characterized by the fact that his disturbance is of a major portion of his personality. Reality is seriously distorted . . . with such phenomena as hallucinations or delusions or serious memory defects or judgment defects or disorientation. He frequently has little or no insight into the fact of his being sick." [5]

The insertion of organic types is admissable. In considering the neuroses reference was made to physical signs "imitating" organic causation. There are, on the other hand, organic cerebral diseases which actually "create" mental symptoms analogous to the psychogenic, or pure psychoses. It was said earlier disorders of this kind can be classified as neuropathies or psychopathies, depending upon the emphasis one chooses. Organic psychoses are essentially neuropathies later complicated by psychopathic adornments. The better known encephalopathies with this duality are caused by known specific inflammations (syphilis), specific intoxications (alcohol), senility and indifferent fevers. Besides the proved cause in the particular instance, an added mark of distinction is that the effect or psychosis passes if the morbidity is removed without permanent detriment to the brain tissue. Only recently have the modern shock therapies offered some hope of fulfilling similar expectations in the larger number of psychogenic psychoses.

(4) Amentia-Dementia (Demented Group)

We leave the distorted and meet with a class that is destitute of mind. The destitute of mind are literally demented. A deprivation of the basic mental qualities is obviously different from a conspicuous diversion of the state of mind. The severely distorted or deranged in the group of psychoses may even be more "insane" than the demented. If the deranged, as used here, are "insane," judged by their violent irrationality and by being "unsound of mind," the demented are equally so by opposite values, that is, by not being sufficiently rational and not being "sound enough of mind." This incompetence of basic faculties is either through lack of endowment (congenital) or by induced deprivation (acquired). The term Amentia qualifies the congenitally derived, and Dementia the acquired.

Amentia: Defective developments range all the way from the dull minded to complete absence of the intellect. Clinical types in the order of increasing amentia are the dull-normals, morons, imbeciles, and idiots. Unusual types include amauratic idiocy and those resulting from congenital brain anomalies, hydrocephalus, etc.

Dementia: Loss of serious impairment of intellect infers an adequate previous possession of the same. Permanent structural damage to brain substance may come from many sources—trauma, inflammations, intoxications, nutritional and endocrinopathic disorders. Some classical clinical entities are: cranial birth-injury paralytic dements, dementia paralytica, alcoholic dementia, senile dementia, pellagra, and cretinism. These processes are simply understood. The story, however, is incomplete without incorporating another broad causation and that does not embarrass the plan of our classification. Dementias accrue in the wake of deteriorations that haunt some psychopathies which progress evilly—schizophrenia, "psychic" epilepsies, chronic manias, chronic melancholia and others. Every dementia has a pedigree.

II. Psychosomatic Disorders

Psychosomatic medicine is a misnomer. The whole of medicine is in principle psychosomatic because the person and his disease are both treated. In a limited sense, psychosomatic disorders describe a particular type of irregularities. In the realm of the psychopathologies, there is a vacancy which must be filled by the understanding of another set of human frailities which marks this type of irregularities.

We recognize physiological disturbances clinically conceived as dysfunctions, without organic foundation, and they are literally called functional disorders. That is a common clinical designation. Exemplary symptom-complexes are blushing and blanching, sweating and inhibition of secretions, racing hearts, phenomenal sighing, revolting stomachs and rebelling colons. The degree of provocation in some people fails to induce the same response in the average person. Symptom-complexes and clinical syndromes of these natures are common events. To express the concept the following descriptive terms are encountered in diagnosis: functional disturbances, functional disorders, nervous instabilities, vasomotor instabilities and constitutional malfunctions. These clinical expressions attempt to convey something different from the descriptive phrases mentioned in connection with the psychoneuroses. They are not mental instabilities, they are outside the will. They are disorganizations in the autonomic mechanism of the organism. Specific clinical entities belonging to this category are

few compared with the number of bizarre unsystematized symptom-complexes. Fairly well defined clinical entities are represented by neurocirculatory asthenia, and the irritable colon syndromes.

There is no voluntary control over these commotions. None of these is promoted directly by the will or mind. They are not psychopathies. The mind may be conditioned or susceptible, but the major fault is a defect in the stop-gaps along the architectural line of the co-ordinating nervous mechanism. In addition to the somatic manifestations, there are counter-parts of emotional reactions or so-called affective responses. These emotional disturbances may be the chief presenting feature. That is not a primary state of mind. Affect or feeling appears to be more of an attribute than an essence of mind. Cortical interrelations with the inner functions are loosely knit "Between the somatic and autonomic nervous system there is an interdependence and reciprocal action. . . ." [6] The process is conceivably reversible. The genesis is a functional physiological disturbance.

This phase raises the question of psyche or soma precedence. The realist is inclined to endorse the physiological view expressed by Cannon, "the most significant feature of those bodily reactions in pain and in the presence of emotion provoking objects is that they are in the nature of reflexes . . . they are not willed movements, indeed, they are often distressingly beyond the control of the will. The pattern of the reaction in these as in other reflexes, is deeply inwrought in the workings of the nervous system, and when the appropriate occasion arises, typical organic responses are invoked through inherent automatisms." [7]

Conclusion

There is a compelling need for greater care and uniformity in the indentification of the psychopathologies. The present situation fosters an estrangement with the scientific data available because of an over-emphasis of details obscuring a wholesome overall view. Arbitrary divisions are better than almost total discordance. In any case, they provide a handy clinical tool. With that objective in mind a plain and forward guide for the inexpert is outlined. The psychopathies are divided into four classes—psychoneuroses, neuroses, psychoses and amentia-dementias. Psychosomatic disorders embrace clinically observed emotional and physical symptom-complexes and a limited number of representative entities. The reasons for the need to adapt the subject matter along practical lines were stated. The aim is to attain a better means of reference to those patients, equal to the standards which govern all other clinical procedures.

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A Rational Approach to Endocrine Therapy in Gynecology

W. F. Abbott, B.A., M.D., C.M., The Abbott Clinic

Moderately recent changes in our knowledge of the physiology of menstruation have undoubtedly been the outstanding factors in the advancement of treatment in Gynecological conditions during the past ten years. The histiological picture of changes in the ovary and endometrium has not fundamentally changed since the classical description by Hitschmann and Adler in 1908. However our concept of the physiological basis of those changes has completely altered from pure hypothesis to actual facts based on clinical and experimental investigation. The bio-chemist has kept abreast of this advancement, in the isolation and production of therapeutically potent preparations, applicable to the various manifestations of dysfunction as we understand them now, on a physiological basis. Unfortunately the application of this knowledge, has not always been applied in a scientific manner. Therefore a brief resume of the known facts may not be amiss.

Review of Endocrine Physiology

Menstruation, ovulation and embedding of the fertilized ovum are not due to an isolated physiological change which occurs in the ovary or uterus, but are the result of a cycle of interrelated changes in the whole endocrine system. Undoubtedly the thyroid gland plays an important role in stimulating and stabilizing metabolism, but in the pituitary gland, the so-called "motor of the ovary," is found the essential stimulant which initiates the cycle of menstruation as understood today. Among several hormonal factors (lactogenic thyroid tropic, growth stimulating, etc.), produced by the anterior portion of this gland, are two with apparently selective and retroactive stimulating effects on the ovary, the latter ceasing to function on removal of this stimulation. The first, a follicle ripening gonadotropic hormone, brings growth, maturation and eventually ovulation in the ovarian follicle and makes possible the production of its specific hormone, estrogen. A second, luteinizing gonadotropic factor controls the conversion of the follicular granulosa and possibly thecal connective tissue into lutein cells which in turn produce their specific hormone progesterone. The chemical structures of the above principles are unknown and they have not been isolated or synthetically simulated. Under control of this pituitary stimulation, the ovarian function is initiated and again two separate and distinct hormones are produced. Although their chemical structure is very similar, differing only in minor hydroxyl grouping, their physiological effect, although reciprocal, is essentially antagonistic to one another. The first, an estrogenic hormone in the form of estradiol, is produced by the granulosal and thecal cells of the ripening follicle. It exhibits a selective action on all tissue derived from the Mullerian ducts, stimulates the growth of the endometrium characterized as the proliferative phase of the menstrual cycle, regulates secondary sex characteristics at puberty, is responsible for the normal rhythmic contractility of the uterine musculature and influences proliferation of the duct system in the mammary gland. A secondary ovarian hormone, stimulated by the pituitary luteinizing factor, is produced by the corpus luteum and known as progesterone. It brings about changes, in an already proliferative endometrium, which we characterize as pregestational, pregravid, predecidual or secretory. This hormone maintains nidation of the embyro in early gestation, tends to inhibit the stimulating effects of estrogen on uterine contractility and inhibits ovulation and follicular maturation during the presence of an actively functioning corpus luteum. An interaction of these four hormonic principles on the ovaries and endometrium brings about the manifestations which we characterize as the menstrual cycle.

During pregnancy, another source of hormonal production is evident. At approximately the end of the third month of gestation the function of the corpus luteum is largely taken over by the placenta. This transitional period is especially important in the treatment of habitual abortion. Large amounts of progesterone, as sodium pregnandiol glucuronadate, are recoverable from the urine and blood of pregnant females at this time, reaching a maximum between the third and fifth month. Also the production of estrogen is largely taken over by the trophoblastic tissue with a cumulative concentration up to just before the end of the gestation period. They form the basis of the Aschheim-Zondek reaction and its various modifications.

At first they were considered as identical with the primary pituitary factors but this has been proven incorrect although the clinical responses produced are very similar. Commercially they have been named Anterior Pituitary like (A.P.L.) substances but a more correct name is Chorionic Hormones.

Source of Production of Biological Products

The commercial preparation of chemical substances containing the active principles of the foregoing hormones has been noteworthy but must be accepted with certain reservations. The primary glandular hormone is always more effective therapeutically than its metabolic derivative

or excretory form (as estradiol, the primary follicular product in comparison with its metabolic modifications estrone or estriol). Some have not been produced in effective forms, others are undoubtedly a mixed secretion with protein impurities and the clinical results do not always substantiate the claims of the manufacturer. Also experimental data is largely based on animal application and the results as compared with those obtained in the human species, is notoriously unreliable. The following main groups may be considered.

1. Anterior Pituitary Natural Extracts

Neither the follicle ripening nor the luteinizing factors have been isolated and their exact chemical formulae are not known. When available they will be of immense value.

2. Chorionic Gonadotropins (A.P.L. Substances) are obtained from three main sources.

(a) Pregnancy urine (equine or human) as Follutein-Squibb; Pregnyl-Roche Organon, and Synadpodin-Parke Davis. They are luteinizing in action.

(b) Placental Extracts-Ayerst A.P.L. also a luteinizing substance.

(c) Pregnant mares serum—as Serogan-B.D.H., Gonadogen-Upjohn and Antex-Ayerst all with reputedly great follicle stimulating properties. It is evident that our choice of preparations to treat primary pituitary deficiencies is limited.

3. Ovarian-Follicular Hormones. Produced in three groups.

(a) Estradiol Derivatives as Ovocylin-Ciba and Progynon-Schering. Certain such estrogens can be modified by a process of esterification into more effective and more stable benzoates and diproprionates as Di-ovocylin-Ciba, Estinyl-Schering and Di-menafarmon-Roche Orgonon.

(b) Estriol Derivatives as Theelol-Parke-Davis, Emmenin-Ayerst and Ostroform-B.D.H. Ayerst Premarin is a modified conjugate equine preparation and apparently very effective.

4. Ovarian-Corpus Luteal Preparations

Natural products as Prolutin-Schering, Progestin-Roche. The excretory form pregnandiol, found in the urine, is inactive therapeutically.

5. Placental Extract

As Ayerst Liq. Emmenin, probably a mixed estrogenic and Progesterone preparation.

6. Synthetic Preparations

Corpus Luteal (Pregneninolene) as Progesterol-Roche Organon, Pranone-Schering and Lutocylol-Ciba. Estrogenic-Stilboestrol-B.D.H., Diethylstilbestrol-Lilly, Diastrol-Frost, Estrobene-Ayerst and Dienoistrol-B.D.H.

They are hydrocarbon derivatives bearing no structural chemical resemblance to natural estrogens. All are administered orally, are inexpensive as compared with the natural products, apparently are effective therapeutically but produce mild toxic reactions in from 5 to 10 percentage of patients.

General Indications in Treatment

Only a brief outline of indications is purposely given as they are found in great detail on all commercial products. This is exactly the fault found in many methods of administering the various hormonal products available. A patient presents herself suffering from excessive uterine bleeding, a quick survey is made of the hormones recommended for menorrhagia by over-zealous detailmen, one is selected that apparently fits the case and she is sent on her way. The only rational plan is to secure a careful history; do an accurate and complete general examination (not merely a pelvic exploration); determine if the condition is caused by general constitutional conditions, pelvic pathology or an endocrine dysfunction; try and explain your diagnosis of cause on a physiological basis and then select the group of products which should correct this condition. It is then time to inspect the list supplied by your favorite Pharmaceutical House and prescribe treatment. It is probably a rational procedure to always determine the conditions of thyroid metabolism before embarking on a long course of estrogenic therapy. Any disorder of menstruation is only a symptom and the majority of cases are not caused by an endocrine dysfunction. The following indications, although obviously very incomplete will serve as a working basis.

Indications for Estrogen Administration

Menopausal symptoms, especially the vasomotor disturbances, caused by deficiency in estrogen and excess in pituitary gonadotropes is naturally benefited. In Amenorrhoea of endocrine origin they are indicated, providing, one remembers that many cases are thyroid or pituitary in origin and even if ovarian the therapy is only substitutional, not having any true stimulating effect on the ovary and not producing ovulation. Primary ovarian sterility is therefore not corrected. Gonorrheal Vulvo-vaginitis in children and senile vaginitis are definite indications. Primary Dysmenorrhoea, if associated with uterine hypoplasia may be added to the list. The older forms of ovarian extract, ovarian residue and corpus lutein extracts are useless, irrational, inert and their manufacture ought to be discontinued.

Indications for Progesterone Therapy

Functional uterine bleeding, characterized by estrogen excess and progesterone deficiency, is

theoretically an indication but the results are inconsistent. Primary Dysmenorrhoea is at times relieved by the sedative action on uterine contraction. The use of Progesterone, following estrogens given in the proliferative phase of the cycle, is recommended by many but it is purely substitutional treatment, and bleeding, if produced, is a pseudo-menstruation and seldom associated with actual ovulation. The chief use of such preparations is in the treatment of threatened or habitual abortion given during the second to fifth month of gestation until the placental production of progesterone is well established. The results are not uniformly successful but a great improvement on any previous treatment.

The preparations of chorionic gonadotropins and hormones and pregnant mares serum have been highly recommended commercially but their clinical exhibition must be undertaken with due allowance for a large percentage of disappointment.

Section of Anaesthesiology

P. C. Lund, M.D., Anaesthetist, Deer Lodge Hospital

Abstract

Malaria and the Anaesthetist

Lockett, John: Brit. J. Anaesth. 19: 113-119 (Jan.), 1945.

"Both men and women will be returning after working in some of the world's most highly malarious areas, and the relapse rate is bound to be high for several years.

As the severity of the operation increases so does the relapse rate.

Practically in all cases the relapse was noted within the first three days after operation; but it is probable that they immediately followed the operative procedure, as it is a well-known fact that trauma of any sort brings out a latent infection. These postoperative relapses are, however, usually mild, quickly controlled by the administration of the usual anti-malarial drugs, and do not unduly prolong the convalescent period. But this is unfortunately not the full picture. If it were so the surgeon and the anaesthetist might treat the problem as purely incidental.

The problem would seem to fall into two divisions: that of the ordinary case where time of operation can be selected; and the acute case which demands immediate action. With regard to the ordinary case, though the post-operative relapse is usually mild, such a relapse might tip the scales against the safe and speedy recovery of the patient.

It is therefore advised that suppressive treatment such as Mepacrine, tablet one, should be given daily in the four days preceding operation and carried on thereafter until the patient is well through the convalescent period. It might be added that a history of no previous malaria is not sufficient to excuse the patient from such a course. The criterion is rather whether he has passed any period in a malarious area.

It may be mentioned here that after this war the list of such areas may be large, namely, North and West Africa, India, Burma, the Far East, including the Pacific Isles, Palestine, the Balkans, Italy, Holland. The emergency cases, may, however, present a very different picture, and one which is fraught with danger during and after operation. In such cases a careful assessment of the situation must be made, and where Malaria of the Malign Tertian type, which can give rise to brain involvements, is proved or even suspected, prompt pre-operative treatment must be instituted.

It is unfortunately true that in such cases lost time often means a lost patient. In view of the urgency of warding against or treating a cerebral involvement, quinine 6 gr. is usually given intravenously. But in 30 to 40 per cent of cases investigated in this hospital a fall of some 10 mm. of mercury blood pressure has been observed. Here lies a difficulty, for this might well make a poor operative risk hopeless. In such cases the intramuscular injection of Mepacrine Methane-Sulphate (Quinacrine) is advised as both efficacious and safe, if administered in doses of 0.15 to 0.25 grm."

P. C. L.

Abstract

Graham, George: Preparation of the diabetic for operation. Proc. Roy. Sec. Med. 38: 547-549 (Aug.), 1945.

"Nowadays diabetes is in no wise a contra-indication for any operation provided that (1) a physician is at hand who knows how to look after these patients; (2) adequate facilities are available for estimation of the blood sugar, etc.; (3) the best anaesthetic is chosen and given by an experienced anesthesiologist; and (4) that the operation is well and quickly done.

The anaesthetic is very important and a local or spinal anaesthetic causes least disturbance. Gas and oxygen is the next best provided sufficient oxygen is given to prevent any cyanosis since the blood sugar is always raised by cyanosis. The intravenous anaesthetic, pentothal comes next and I have seen no ill-effect from these. Ether, which may be necessary to get complete relaxation with gas and oxygen, does raise the blood sugar and should be used only in small amounts. Avertin

is better not used because it lowers the glycogen in the liver by 50 per cent and so, renders the liver more liable to damage. Finally, chloroform should never be used because of its action on the liver. When an operation has to be performed the diabetic condition should be as well controlled as possible.

Morphia is always given to sedate the patient, but it tends to make the patient's breathing more shallow and increases the tendency to anoxia; the dose should be as small as possible, 1/6th grain of morphia.) It is most important that the patient should not be starved before operation as this will reduce the amount of glycogen in the liver.

If the operation is timed for 12 noon to 3.30 p.m., he should be given his usual breakfast and insulin at the ordinary time. Then two hours before the time of the operation he should have 25 units of insulin followed by 50 grammes of glucose in place of the usual mid-day meal.

If the dose of insulin and sugar is arranged somewhat on these lines the anaesthetic will not do the diabetic condition any harm. The only complication which may occur is hypoglycaemia. This will not show itself during the operation as this, together with the anaesthetic, will certainly cause a rise in the blood sugar. The mild symptoms will probably pass unnoticed but the patient may not recover consciousness at the right time after the operation in which case an intravenous injection of glucose should be given."

P. C. L.

Something Old

Spanish Practice

Our "Something Old" for this month is taken from Richard Ford's "Gatherings in Spain," a delightfully entertaining book which is quite as enjoyable today as it was in 1846 when it was published. There is a story told of Adam revisiting the Earth. He found Italy perplexing, Germany bewildering, England was beyond his comprehension, France was baffling, Russia he did not visit but when he went to Spain he found that nothing had changed since his last visit. And not much has changed there since. In almost every way Spain has lingered centuries behind the rest of the World. Anyone who wishes to read "Gatherings in Spain" can get it in the "Everyman's Library."

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Etiquette is the life of a Spaniard, and often his death, since every one has heard (the Spaniards swear it is all a French lie) that Philip III was killed, rather than violate a form. He was seated too near the fire, and, although burning, of course as king of Spain the impropriety of moving himself never entered his head, and when he requested one of his attendants to do so, none, in the absence of the proper officer whose duty it was to superintend the royal chair, ventured to take that improper liberty. In case of sudden emergencies among her Catholic Majesty's subjects, unless the family doctor be present, any other one, even if called in, generally declines acting until the regular Esculapius arrives. An English medical friend of ours saved a Spaniard's life by chancing to arrive when the patient, in an apoplectic fit, was foaming at the mouth and wrestling with death; all this time a strange doctor was sitting quietly in the next room smoking his cigar at the brasero, the chafing-dish, with the women of the family. Our friend instantly took 30 ounces from the sufferer's arm, not one of the Spanish party even moving from their seats. Thus Apollo preserved him!

As a general rule at the first visit, they look as wise as possible, shake their heads before the women, and always magnify the complaint, which is a safe proceeding all over the world, since all physicians can either cure or kill the patient; in the first event they get greater credit and reward, while in the other alternative, the disease, having been beyond the reach of art, bears the blame. The medicos exhibit considerable ingenuity in prolonging an apparent necessity for a continuance of their visits. A common interest induces them to pull together—a rare exception in Spain—and play into each other's hands. The family doctor, whenever appearances will in anywise justify him, becomes alarmed, and requires a consultation. A Junta. What any Spanish Junta is in affairs of peace or war need not be explained; and these are, like the rest, they either do nothing, or what they do, is badly. At these meetings from three to seven Medicos de apelacion, consulting physicians, attend, or more, according to the patient's purse; each goes to the sick man, feels his pulse, asks him some question, and then retires to the next room to consult, generally allowing the invalid the benefit of hearing what passes. The Protomedico, or senior, takes the chair; and while all are lighting their cigars, the family doctor opens the case, by stating the birth, parentage and history of the patient, his constitution, the complaint, and the medicines hitherto prescribed. The senior next rises, and gives his opinion, often speaking for half an hour; the others follow in their rotation, and then the Protomedico, like a judge, sums up, going over each opinion with

comments; the usual termination is either to confirm the previous treatment, or make some insignificant alteration: the only certain thing is to appoint another consultation for the next day, for which the fees are heavy, each taking three to five dollars. The consultation often lasts many hours, and becomes at last a chronic complaint.

Ford "Gatherings in Spain"

Winnipeg Medical Society—Notice Board

Next Meeting
October 18th

This year the Notice Board will be under new management. It was started originally during my term of office as President of the Society and for the purpose of advertising our meetings and doings. During the past two years I have been too much out of touch with things to have been able to give the information proper in this place; so I have asked Dr. Tisdale to appoint some member of the Executive to carry on.

On every occasion last year our meeting fell upon a date important in medical history. On October 24th, 1537, Jane Seymour, consort of Henry VIII and mother of Edward VI, died of puerperal sepsis. The circumstances of her death are not, however, of great interest. More interesting are events which occurred on the days following the Battle of Edgehill (October 23rd, 1642) and consequently I shall give these instead.

Battle of Edgehill: Remarkable Cases of Suspended Animation

The Battle of Edgehill, in which both the Royalist and Parliamentary party claimed the victory, took place on the morning of Sunday, October 23, 1642. Amongst those who fell on the King's side, and were left on the field as dead, was Sir Gervase Scroop, who had fallen covered with wounds about three o'clock on Sunday afternoon. It was not till Tuesday night that his son, who was also in the King's forces, was able to return to the battle-field to search for the body of his father. When he found it, it was perfectly naked, having been stripped, like the rest of the slain, on Sunday evening, by camp-plunderers. In this state it had lain all Sunday night, all Monday, and Monday night, and was apparently dead, having received no less than sixteen severe wounds. Monday night, it ought to be stated, had been remarkably cold and frosty. Sir Gervase's son carried him to a lodging near at hand, and fancied he felt in the body some degree of heat. "That heat," says Fuller, "was, with rubbing, within few minutes, improved into motion: that motion, within some hours, into sense: within a day, into speech: that speech, within certain weeks, into a perfect recovery: living more than ten years after, a monument of God's mercy and his son's affection. The effect of his story I received from his own mouth." The next day (Wednesday, 26th October), another gentleman, named Bellingham, was found in a like condition among the dead, having received twenty wounds. Being carried off by his friends, he also was restored, and lived for ten days, but died subsequently from one of his wounds terminating in a gangrene. "The surgeons were of the opinion," says Clarendon, "that both these gentlemen owed their lives to the inhumanity of those who stripped them, and to the coldness of the nights, which stopped their blood, better than all their skill and medicaments could have done, and that if they had been brought off within any reasonable distance of time after their wounds, they had undoubtedly perished."

In connection with the subject of unexpected reanimation, the case of Sir Hugh Ackland, of Kellerton, Devonshire, may be mentioned as even more extraordinary. This gentleman was seized with a violent fever, and having apparently expired, had been laid out as dead. The nurse and two footmen were appointed to sit up through the night to watch the corpse. Lady Ackland, to cheer them, had sent them a bottle of brandy, whereupon one of the footmen, "being an arch rogue," said to the other: "Master dearly loved brandy when he was alive, and now, though he is dead, I am determined he shall have a glass with us." Accordingly, he poured out a bumper, and forced it down Sir Hugh's throat. A gurgling noise immediately ensued, accompanied with a violent motion of the neck and upper part of the chest. A terrible consternation seized the watchers, who rushed violently down stairs: "the brandy genius" with such speed that he fell, and rolled head-over-heels, bumping down from step to step till he reached the bottom: while the nurse screamed with terror. The noise having roused a young gentleman who was sleeping in the house, he immediately got up, and went to the room where the noise had first begun. There, to his astonishment, he saw Sir Hugh sitting upright on the bed. He summoned the servants, and ordering them to place their master in a warm bed, sent off for his medical attendants. In a few weeks, Sir Hugh was restored to perfect health, and lived many years afterwards. He often used to relate this strange story of his own resuscitation by his footman's facetious conceit, for which he is said to have bequeathed him a handsome annuity.

Chambin, "The Book of Days."

Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor

An Answer to Critics

At the business meeting of the Association the matter of the C.P. and S. was brought up. My comments as published in the September issue, and I myself were subjected to drastic and vigorous criticism. Unfortunately I was unable to attend the meeting and, as I had nothing in writing from my critics, I have only second-hand knowledge of what transpired. I cannot, therefore, be sure that all the criticisms then made are now being answered. A letter from the Registrar enumerating the points at issue would have been a more satisfactory basis for a reply. However, I gather that I was accused of making false statements and of resorting to personalities. Dr. Campbell, the Registrar, felt that I deserved public censure and that he himself was entitled to an apology.

I am very aware of the importance of accuracy in speaking and writing. No one who makes loose, misleading or false statements will for long be believed and I have no desire to be regarded as unreliable. Therefore I made certain that I had good authority for every statement I made in the offending article which, incidentally, I neither meant nor expected to give offence.

I wrote, "The Registrar was asked for the information (i.e. list of voters in each constituency) but said that to do so would be an infraction of the Act." It was not I who asked and was refused but Dr. McNulty, who told me of the incident and approved the above quoted sentence before it was printed. The details of election procedure I had from Dr. Prendergast, a Member of Council and a former President of the College. He read and approved what I had written before it was printed. I stated that nomination and ballot papers passed through the hands of the Registrar. The return envelopes are so addressed and these documents cannot legally go to anyone else. I did not suggest that the Registrar, when a candidate, took advantage of this because I do not believe he did. But it is a fact that the papers are sent to him, and it is a fact that he, while a candidate, can legally handle them, and it is a fact that such a procedure is highly undesirable. That was what I wrote and all I wrote and inasmuch as it is neither untrue nor offensive I repeat it.

I wrote that the scrutineers might also have been nominated. This I regarded as a possibility but scarcely thought that any candidate had ever counted his votes. Since then I have been informed by a former member of Council that he was a scrutineer at his own election and counted his own votes. He did not abuse his anomalous position but that does not alter the fact that appointing as a scrutineer one who is also a candidate is a most objectionable practice. I said that I did not know how ties were broken. This, apparently, is a duty of the Registrar in his capacity of Returning Officer, an embarrassing duty, one would think, were he an affected candidate.

I did not state as a fact that there was a two-member constituency. Dr. McNulty had heard there was and this led to his request for the number of voters in each district. The discrepancy between North Winnipeg and South Winnipeg in the matter of representation was alone sufficient to give point to my argument.

I was $9,000 out in my estimate of the wealth of the College. The financial report (published in the April issue of the Review) gives the following figures: Gordon Bell Account, $23,000; Investment Account, $47,796.96; Revenue Account, $2,000. Somewhere there is an overlapping which reduces the amount to $51,000. The exact amount of idle money is less important than the fact that it is large and idle.

I made it very clear that I was not criticising the Members of Council, but it is impossible to condemn a system without obliquely criticising those who have permitted it to exist. I had no barbs for anyone. I believe that the Members of Council are honourable men sincerely anxious to serve us well, and I would be sorry to think that any Member felt that I had been unfair or unjust to him. But I would be sorrier still if I thought that our medical democracy had sunk so low that criticism is taken for suspicion, that condemnation of a system is taken as a personal affront, that a critic dare not speak his mind without hearing the cry "Off with his head," that those who by reason of their positions must expect criticism, reply to it by demanding the censure of their critics. That used to be the fashion in Germany but has never been the fashion here.

The fact is that our Council has never before had its procedures criticised and, being accustomed to make decisions from which there is no appeal, they forget that they are subject to the same conditions which prevail in every elected body. It would be a novelty in any Municipal Council if the Secretary were to demand the scolding of every tax-payer who criticised the Municipal Act, or if a member of parliament in his own constituency were to ask for the punishment of every constituent who criticised the system of government.

I understand that the Registrar spoke about previous Councils considering the question of representation. I have no doubt that other matters sorely in need of reform have also been discussed and left un-reformed for presumably good reasons. But we cannot know, unless we are told, what the Council may discuss, or what their decisions may be, or how their decisions are reached. If the Council wish us to do justice to them and if they wish to do justice to themselves and if they wish to do justice to us they must emerge from their ivory tower and tell us what they have done and are doing.

Far from indulging in personalities I avoided them. I wrote "This is not a criticism of the Members of Council. It is not the fault of the Registrar if he is nominated and elected. He is not to blame if the ballots pass through his hands." Does that require an apology? I wrote that the ballots were sent to the Registrar. I did not even say that he opened them, though up to the present election when the ballots were open he could quite legitimately have done so. Am I to apologise because I say one receives letters addressed to himself? I said that for candidates to have anything to do with the handling of their ballots was bad practice and so it is universally considered, so why should I apologise for saying it? I said that certain information had been refused but I did not say that it had been refused to me and I believe what Dr. McNulty told me and, moreover, I blamed the refusal upon the Act. I cannot see in that anything for which an apology is called.

I said that the Registrar should be appointed in some other way than as at present and so he should. Moreover he should hold himself responsible not to a small Council or a smaller Executive Committee but to the whole body of the College whom he is employed to serve, whose wishes, therefore, should be his guide, whose instructions should be his law, and before whom, at stated intervals, he should appear to hear these wishes, receive these instructions, and be awarded such measure of praise or of blame as his past actions may have merited. That is merely established and accepted practice which is too universal to ask for apology. Indeed I think that if apologies are in order I have an excellent case myself!

I made it as clear as I could that I was attacking an outmoded Act full of anomalies. It was proper enough for a king of France to say "The State! I am the State." But one could scarcely expect any member of Council to take to heart what I said about the Act as if he were the Act. I took it for granted that the Members of Council were doing the best they could in spite of the Act. I did not even suggest that they had allowed to remain unchanged things that they could have changed. It therefore distresses me to think that what I wrote simply, clearly and sincerely should have been misconstrued into an attack upon anyone. Nevertheless it would appear that I have been misconstrued and I regret the fact; but, however, much as I may regret it, I see nothing to retract, nothing for which to apologise, nothing deserving a vote of censure. I exercised a constitutional right as a Member of the College. I wrote without malice. I set forth the facts as I had them. I did not "exaggerate the facts for the sake of emphasis" as one of my friends said in my defense. There is no need to exaggerate when the facts are so grotesque that the naked truth itself seems an exaggeration.

I believe that we have a bad Act and so I assailed it with vigor. My veracity and intentions were, I understand, so severely attacked that I must defend myself now with vigor. But I do so without bitterness or any desire to "get even." I have no quarrel with any member of the Council, and if hard words were said about me I prefer to believe that it was because some thought they had to defend when all that was expected of them was to explain.

Brandon and District Medical Association

The Fall Meeting of the Brandon and District Medical Association was held Wednesday, September 4th, 1946, at the Prince Edward Hotel, Brandon. The weather was exceptionally fine and the largest attendance in the history of the Association was recorded.

Forty-five doctors attended the scientific session in the afternoon.

The majority of the visitors, accompanied by their wives, attended dinner which was served in the evening.

The visiting speakers and the subjects on which they spoke are as follows:

Dr. P. H. T. Thorlakson, "Some Problems in the Management of Thyroid Disease."

Dr. F. G. Allison, "The Management of Heart Disease."

Dr. W. S. Peters, "Three Very Interesting Obstetrical Cases."

Dr. M. H. Ivens, of Carberry, "A post prandial talk on his experience with the American Army in the Pacific War Theatre."

During the afternoon the visiting ladies were entertained at the Brandon Golf and Country Club.

Visitors were present from as far away as Dauphin and Portage la Prairie.

J. E. Skafel, Hon. Sec.-Treas.

What Rural Manitoba Expects of Medicine

Address by Mr. Geo. N. McConnell, Presented at the Annual Meeting of the Manitoba Medical Association, September 23, 1946

Mr. Chairman and Gentlemen:

I feel I should first express the thanks and appreciation of the Board of Manitoba Pool Elevators for the invitation extended from your Association that an actual farmer who could speak for rural Manitoba be given this opportunity to place some of his ideas before this distinguished group.

The Town and Municipality of Hamiota from which I come has been well and faithfully served by Dr. Hudson, who is well and favorably known to most of you gentlemen—a man who in the practice of his profession, and whose sense of leadership and social responsibility has gained the respect and confidence of all who know him. It is this relationship of the family doctor to our community—this service that we have received in the last forty years from a man who, in the practice of his profession, has been able to do so much in caring for the health needs of that area—which leads me to believe that if all rural Manitoba had been as fortunate as we have been there would be little need for me to appear before this group today to explain what further requirements rural Manitoba should have in the way of health facilities.

The practice of medicine is a high calling in life—I have always associated healing and the ministry as being closely allied. As you will recall, the first and greatest missionary of all times was also a healer. It was said of Him that "He went about doing good"—service was the keynote of His life on earth. In my remarks this afternoon I want to pay tribute to the excellent work done by our Ministers, Doctors, Nurses and Teachers. I associate this group together because they are all in a position to offer leadership, possibly required and expected more in rural areas than in urban. As a farmer speaking for rural people, it is this leadership—this sense of social responsibility—this interest in better health, in more and better doctors, dentists and nurses, in more adequate hospital facilities, in more equity of service as between urban and rural centres, that I particularly wish to stress.

I am not going to worry you with statistics, but a few are necessary to prove my point about equity of service as between rural and urban areas. The ratio of doctors in Greater Winnipeg is slightly less than one per thousand population. When you consider that there are 669 actual practitioners in the Province of Manitoba and you find a concentration of 62% of them serving cities with over 30,000 population, of which there is only one—Winnipeg—(62% of the doctors serving 33% of the people)—you realize that Rural Manitoba, with over 56% of the population, has a real scarcity of doctors. Outside of Winnipeg and including centres such as Portage la Prairie, Brandon and Dauphin the ratio is one per three thousand population; in strictly rural areas it is closer to one per four thousand. Reasonable health needs would seem to require one doctor per 700 population. The Armed Services required one doctor to 669 service personnel, and when you realize that the Forces included the young and physically fit, it is evident that one doctor can not serve efficiently a rural area with 4,000 population. Outside of Greater Winnipeg there is only one place (Brandon) where complete diagnostic facilities are available, which makes it still more difficult for the rural practitioner to serve his sparsely settled community.

Nurses are scarce in rural areas and it is only rarely a farm family can secure the services of a trained nurse, no matter how urgent the need. In 1943 the ratio of private duty nurses was one to every two thousand population, so it is no wonder that country people are unable to secure adequate nursing service.

While rural hospitalization facilities are by no means sufficient to serve the rural areas, I think my own doctor to whom I have referred, will be the first one to admit that the service he has been able to give our community has only been possible because he has had the assistance of the Municipal hospital situated in Hamiota.

From the Manitoba Hospital Commission Report published in 1944 we learn that out of a total of 3,013 hospital beds in all Manitoba, 2,084 are in greater Winnipeg, and that of total hospitalization 75% is in Greater Winnipeg, where the population is approximately only 40% of the provincial total. When you consider that 56% of Manitoba's population is rural, it is not surprising that the Winnipeg public general hospital beds have served rural patients an average of 20,000 patient days during the last five years. We have never contended that the cities have too many hospital beds, but we do claim that rural hospital construction is so far behind it should have top priority to give equitable service to country people and thereby relieve congestion in city hospitals which would, incidentally, give better service to urban residents. There is no doubt, Gentlemen, that if we had more rural hospital facilities there would be a greater tendency for doctors to seek rural practice. It is quite conceivable that if we had adequate rural hospital facilities, the present

urban hospitals would be reasonably adequate to meet present needs.

I think I should mention at this time that the shortage and distribution of dentists and dental service is about on a parallel with doctors in rural areas. We have too great a concentration of dentists serving urban centres.

The Canadian infant mortality rate is scandalously high, about twice that of Sweden and New Zealand and 19% higher than in the United States. There has been a slight decline in infant mortality the past two years, but the rate per thousand live births is far above what it should be, and what it would be with proper pre-natal care and proper care of mothers and children when the babies are born and in the first months of infancy. For the past five years our rural infant mortality rate has been from 55 to 60 per 1,000 live births as compared with from 30 to 42 per 1,000 live births in our urban areas. In fact, in 1943 the infant death rate in rural Manitoba is reported to have been 60.3, as compared to 40.4 in urban areas. In areas served by Municipal doctors the rural rate was 40.2. To really bring home what these figures mean—we are greatly concerned over the loss of 41,000 of our youth in the six years of armed conflict. In the same period of time, Canada has lost 130,000 infants in their first six months of life.

The figures given in the report of the Medical Procurement and Assignment Board and the Dominion Bureau of Statistics are substantially higher than the provincial statistics I have quoted.

Gentlemen, we cannot allow this condition to continue. Sir Arthur Newsholme, author of "Vital Statistics," said a lot in two brief sentences which I quote: "Infant mortality is the most sensitive index we possess of social welfare. If babies were well born and well cared for, their mortality would be negligible."

At this point I would also like to quote the Mayor of Coventry in England, which city you will recall was badly blitzed during the early years of the war. To a certain group of Canadian visitors he remarked that the Mayor and Council of Coventry had been trying to remove that slum area for twenty-five years, because the slum conditions and the incidence of disease had caused deaths of 15,000 mothers and infants per year.

Farming is rated a hazardous occupation. In 1944 farm accidents in Alberta caused 288 fatalities, 28,000-odd injuries and an economic loss, excluding fire, of 18 million dollars. Doubtless the other agricultural provinces would show a similar condition. Most of these accidents are of a type requiring immediate medical attention and hospital care with the least possible delay. Without more doctors and rural hospitals this means more deaths and more permanently crippled than would result from a similar type of accident in urban centres. I would like to give one instance. Some of you will recall an accident that occurred on a farm near Brookdale or Wellwood a year ago. A farmer was operating a tractor power binder and on going around opening up the field for the first run was brushed off the tractor by an overhanging limb of a tree. He fell in front of the binder and received terrible injuries. By the time the neighbors were able to extricate him and arrangements had been made in Winnipeg to forward an ambulance, some confusion in the arrangements resulted in the truck in which he was taken to Portage la Prairie to await the coming of the ambulance being delayed, and it was some eight or ten hours before he arrived in Winnipeg to receive attention. I quote this instance, Gentlemen, as just one of many that justify rural demands for more adequate medical and hospital services.

I would like to give one more illustration in proof that rural areas are not the most healthful places in which to live and that we do require some adjustments in health services and preventive medicine. The advent of war makes a nation conscious of its health. A 32-page booklet published in 1946 by the United States' Department of Agriculture and called "Better Health for Rural America" contained the following: "Among nine million draftees examined, 43 out of every 100 were rejected for health reasons, but among those coming from farms 53 out of every 100 were turned down." And still we always think of the rural areas as where we might look for the physically strong and fit. I can recall that the percentage of physical fitness in certain areas in our province was no better, and in the severe drouth stricken areas in Saskatchewan it was much worse. When you recall that the men who were examined for physical fitness for the Forces in 1939 were boys of possibly 10 to 14 years of age in those years of drouth in the early 30's when the economy of Saskatchewan particularly sank to an all-time low, I think you will agree that **malnutrition** played a very important part in the physical fitness tests when soldiers were wanted in 1939 and 1940.

That is all the statistics, Gentlemen. I think they are conclusive, in that they prove definitely we need more trained personnel, more hospitals, more preventive medicine and a health program for the future, more particularly as it applies to rural Manitoba. It is an actual fact that as the standard of living is raised the incidence of disease is lowered. A high standard of living, a sound agricultural economy and some stability and security would seem to be as much the concern of the group I have stressed as being in a position to give leadership, as they are of the people they

serve. I believe it to be true that in the interests of health, all groups should receive a fair share of the wealth of the nation, or the national income. This would enable them to have better and more modern homes, running water and hydro facilities as they are made available, which would mean so much in providing better lighting facilities, labor saving devices in the homes—thereby providing a much better rural environment, which lends itself to better health conditions.

That the rural people of Manitoba are interested in this kind of economy and in modernizing their homes is proven by their unanimous support of the Provincial Hydro and their impatience with the delay caused by shortage of materials.

Rural slum conditions are just as common as urban slums, but I believe that the rural people are resolved to establish and maintain an economy to which their efforts and production entitle them —one that will remove the slums and will further provide them with the amenities of life which in urban centres are felt to be necessities—good homes, good roads, good schools, service by Hydro, adequate health facilities and recreational centres.

The Co-operative organization which I represent, Manitoba Pool Elevators, stands firmly behind that kind of rural programme; in fact, I would hope that it could be said that we have encouraged and helped develop a greater interest in improving rural economy and fostering a broader interest in the general welfare of all rural people.

The rural people are extremely interested in having adequate health facilities. I believe they know what they want. They are prepared to co-operate with the necessary groups to get it, and they are in the soundest economic position they have ever been in to pay their legitimate share of preventive medicine costs.

At this point I would like to make the following statement. I think it is right to say that people generally, and certainly the rural people, should be more interested in preventive medicine and health services, and recognize that if they had adequate preventive medical health services there wouldn't be such a crying need for curative medicine and operative surgery.

Preventive medicine raises the question of the kind of doctor you want, which is the family practitioner—the one who knows a lot about many things but may not be a specialist in any one. He takes care of the common, everyday ailments, advises on nutrition, etc. His moral integrity and absolute honesty compels him to seek advice from the specialist or take his patient to one when the need calls for more than his ordinary practitioner's skill. He knows he has the confidence of the people he serves in his community and the knowledge adds to his feelings of social responsibility.

This relationship, Gentlemen, must be retained at all costs. The trend today is definitely away from rural practice. Out of 249 physicians released from the Armed Services, only 31 have located for general practice in rural Manitoba. I am going to ask you WHY?

To me as a layman this would seem to be a challenge to the Medical Association of Manitoba. I have given you statistics to prove that if they were properly distributed there are sufficient doctors to have a ratio of about one to 1,200 persons, and still we have strictly rural areas with a ratio of one to four thousand population. The wastage of doctors through death, age and emigration is 28 or 30 per year in Manitoba. Our Medical School has been accepting and graduating some sixty doctors yearly, and this year when there is an over-all shortage of doctors and when, as I have proven conclusively, there is a reluctance on the part of doctors to practice in rural areas, we feel there should be more students accepted in the Medical School.

I am going to speak quite frankly at this point, Gentlemen, and coming from a layman it may be deemed an impertinence, for after all the methods of training doctors and the mechanics and facilities for so doing are the concern of the Government, the University and the Medical teaching faculty. With the greater interest that is being displayed by rural people in medical care, and the reluctance of doctors to practice in rural areas, coupled with the greater tendency toward group practice among doctors, I believe it is the responsibility of the doctors to give a greater equity of service. In other words. distribute the service they provide, or else the people are going to insist on more doctors being trained until we have a surplus of doctors and the competition will be such that more doctors will seek rural practice.

I think, Gentlemen. we realize what is taking place today in Great Britain, New Zealand and, much closer to home, in the provinces of Saskatchewan and Alberta, and to some extent in the Province of Manitoba. Maybe you doctors don't like the term Municipal Doctors on salaries rather than on fee, maybe you don't like the term State Medicine or National Medicine as it is referred to in Russia, or Socialized Medicine—call it what you like—but very bluntly it boils down to this: Is the practice of medicine for the benefit of the Doctor, or is it for Service to the people? That is the challenge you have to face.

Dr. Shackleton Bailey, in writing to the British Medical Journal and speaking on the reform of health services in that country, remarked that to some extent they had lost the sympathetic interest

of the public and from now on they must face a more rapid evolution in the practice of medicine at the hands of the Government, and that it will have to be Co-operation from now on.

A moment ago I stressed that in my opinion the family practitioner was the ideal type of rural doctor. If we are going to discourage the centralization of doctors in the more densely populated areas where there are more facilities, and in turn encourage more doctors to practice in rural areas, I am quite willing to admit that rural people have a responsibility, and that responsibility is to furnish good roads and travel conditions that are at least reasonable; and supply Hydro and hospital service, so that the rural practitioner has modern equipment with which to work. To do this we must try to maintain an agricultural economy that will permit medical services to receive fair income for value rendered.

It is just possible that if we had more security of income for the rural doctor, even if it was on a salary basis, it might give more encouragement. To me, as a layman, a private practice in a rural community with adequate hospital facilities should be more attractive and have more future for him as an individual than being one of a group in an urban area.

If we are to work out a more equitable health insurance programme in Manitoba it will require co-operation and goodwill on all sides. If in that plan we hope to retain an adequate supply of family doctors, it would appear that some changes in the direction of the teaching of the medical student should be effected. More emphasis should be placed on social responsibility and preventive medicine and more importance attached to the ultimate goal of graduating a family practitioner.

I think you will agree with me, Gentlemen, that the years the student spends in training, when he is between 18 and 24 years of age, are very impressionable ones, and the idealism, environment and direction of the Medical Teaching Faculty is certainly going to have an important bearing on that student graduate's attitude to the social responsibilities that he assumes as a doctor.

In the past the greatest emphasis has been on curative medicine — not preventive. This calls for specialists, and I believe we can not all be specialists. More than that, while the modern clinic has a very important place to fill, many of our people will never be in a financial position to take advantage of one when possibly a visit to the doctor would serve the purpose.

What the people want is results, **service,** without channelling every surgical case to one or two large centres. I believe many doctors will agree with me that there is a distinct advantage in having one's patient in familiar surroundings and among friends, rather than 200 miles away in strange surroundings with perfect strangers in attendance. I believe this is especially true in the medical care of women and younger children. I doubt if any one of us realizes the mental anxiety of a mother who requires medical care and has to go a long distance from home to receive it and leave her small family at home with possibly not the best help and supervision.

I feel I should say a word or two about nutrition, an adequate diet and the proper kind of food. Science today, and I refer to Medical Research, has given some valuable assistance to doctors and this in turn is shared with the public. One has only to think of Insulin, Sulpha Drugs, Penicillin and new techniques employed to realize the assistance that Science has given doctors, who in turn have been able to bring these benefits to the public in the practice of medicine. It is of interest to note that for the first time in history, Medical Research was given top priority during the last war for the production of penicillin. Agricultural science has also made progress, and the western farmer has proved himself a willing student to make use of these new techniques —mechanized farming and use of new rust resisting varieties which have added hundreds of millions of dollars to the economy of all Canadian citizens, and is one of the most important contributing factors why rural people find themselves in a financial position to support a health plan.

I started out to say something about good food, a balanced diet, proper nutrition. One hears those terms used every day, but what are we doing about it? No country in the world produces more good food, but we do lack in variety in seasonal periods. Also it is quite apparent that with our system of cropping, soil deficiencies of certain elements are becoming apparent and these deficiencies are in turn reflected in our cereals, grasses and hay crops, roots, vegetables and some fruits. That these deficiencies are carried forward in human food was amply demonstrated by the special diets for special services required by some branches of the Armed Forces. In all cases improvement was noted in less fatigue, better eyesight, etc.

As a farmer, it is common knowledge that because of agricultural science we can now detect these soil deficiencies as made apparent by the growth and well being of the farm animals, and we make up these deficiencies by adding lime, salt, iodine, phosphorous, iron and concentrates to balance the ration.

I think, Gentlemen, that we can all agree there is quite a division of opinion about the value of

commercial white flour, which forms a larger part of the diet of Canadian people. We do know that to make commercial white flour the germ, bran and the midlings are removed, which leaves a product that can be stored indefinitely. On the other hand we do know that the ingredients which are removed are the most valuable. I would like to give you an illustration. In a conversation one day, Dr. Smallman, Dominion Entomologist, was reporting on some experiments he had been making. During the war years when large amounts of wheat were being stored we were much concerned with mites in the grain. In his experiments, mites were given different treatment—some were allowed to feed on whole wheat, some on the middlings, some on the commercial white flour and some on vitamin fortified flour. In all cases where the mites had access to the germ and the bran they were robust and produced large families; those with access only to white flour folded up and died. I wonder, Gentlemen, if there is not a lesson to be learned here in the dietary habits that we as a people continue to follow. Possibly with greater research, commercial white flour would be one of the first things that in the interests of good health we could get along without.

In conclusion I want to mention the proposed Hospital Plan evolved by the Provincial Government of Manitoba. This system of hospitalization calls for a Medical Centre to train the necessary personnel, four Regional hospitals, 32 District Hospitals and 78 Rural Health Centres. If this plan can be carried out it would provide hospital accommodation within a reasonable distance of all Manitoba citizens, and also a training centre for the necessary personnel to serve them. Again I wish to stress the over-all shortage of doctors—the mal distribution of the available doctors—the building programme which is envisaged in acquiring more hospital facilities to serve rural Manitoba—and what we feel to be a lack of sufficient acceptances of medical students, because certainly as this plan proceeds, we of necessity will require more doctors.

As a farmer I believe that now is the time to acquire these facilities and proceed to put a Health Plan into action. Of necessity it will take time, and require education of the people, organization, training of adequate personnel, building materials, etc. This will take years to accomplish. It is quite possible that the Plan as envisaged will never be wholly completed, but on the other hand if we only manage to get half the Plan, what a difference it would mean to rural Manitoba. I believe the rural people will do their part. We are enjoying a sound economy at present. Indebtedness is at a minimum and we have some stability of prices and security for a number of years at least.

I would add this warning. No financial burden should be imposed on Municipalities that will bring farm taxes higher than $100.00 per quarter section, including school taxes, special levy and general tax. In my opinion that is the limit that can properly be assessed and met from farm income. No plan that will impoverish rural Manitoba and place farmers in the impossible position in which they found themselves in the 30's can succeed. Even if the cost exceeds the figure mentioned I feel that the rural areas are justified in expecting this hospital service because of the contribution they make to the overall economy of Manitoba, which makes it profitable for the centralization of the people in Winnipeg to enjoy the service of 62% of the available doctors. In other words, if the cost exceeds this figure, the taxpayers of Manitoba should contribute equally to the cost.

This brings me back to the national economy of Canada. Some years ago, in Winnipeg, the late Sir Josiah Stamp (an outstanding English economist) made the statement that for over 100 years the farmers had fed the world at less than cost of production.

If Manitoba, and particularly rural Manitoba, is to enjoy the health services the rural people rightly and justly deserve, it is absolutely necessary that the agricultural economy be maintained at around the present level.

Manitoba Pool Elevators' membership of 23,000 has placed itself on record as endorsing preventive medicine and the Government Hospital Plan. Out of the savings of their elevator organization in 1945 they have voluntarily voted approximately $200,000 in support of building country hospitals. Resolutions to come before the Annual Meeting of delegates this next October would indicate further support and co-operation.

Rural people are also interested in the prepayment of medical protection, as indicated by their support of the Manitoba Hospital Service Association, commonly referred to as the Blue Cross plan. The latest statistics indicate that of 14,000 members of 271 groups, 7,000 are members of Manitoba Pool Elevators.

The farm organizations across Canada are supporting a better health programme as indicated by the submissions made by the Manitoba Federation of Agriculture and Co-operation, and Manitoba Pool Elevators, and similar submissions by the nine provinces and adopted at the Annual Meeting of the Canadian Federation of Agriculture.

There is a great deal of unrest in the world following World War 2, but humanity is on the

march for better living conditions, and they are not going back to what was considered normal. I believe, Gentlemen, that we are going to have planning in health, and it seems reasonable that we should practice preventive medicine to keep our people well.

It has been stated that the Health of a Nation is the Wealth of a Nation. Gentlemen, let us resolve to make Manitoba at least the richest part of Canada in good health. I believe, Mr. President, that with amity, goodwill and co-operation from all groups it can be done.

College of Physicians and Surgeons of Manitoba

Registration Committee

Winnipeg, July 10, 1946

A meeting of the Registration Committee was held on Wednesday, July 10th, 1946.

Present: Dr. Wm. Turnbull and Dr. W. G. Campbell.

Consideration of the Application for Registration of Dr. Michael Bruser

Dr. Bruser was anxious to become registered with the College of Physicians and Surgeons of Manitoba as he was leaving at once for England to do post-graduate work, and needed a certificate from the College of Physicians and Surgeons to become registered with the General Medical Council of Great Britain.

Dr. Bruser received his M.D. degree from the University of Alberta in 1939, and was registered with the Medical Council of Canada the same year. A Basic Science Certificate accompanied his application.

Motion:

Moved by Dr. Wm. Turnbull, Seconded by Dr. W. G. Campbell: "THAT Dr. Michael Bruser's application for registration be accepted." Carried.

Registration Committee

Winnipeg, Man., July 30, 1946

A meeting of the Registration Committee was held on Tuesday, July 30th, 1946.

Present: Drs. T. Digby Wheeler, W. G. Campbell and Wm. Turnbull.

1. Confirmation of the Issuing of an Enabling Certificate to Dr. Donald Hugh Paterson.

Dr. Paterson was a graduate in Science of the University of Manitoba in 1912. His Medical Course was taken in Edinburgh, and he is an F.R.C.S. of London. On account of delays in obtaining his full credentials in the early part of June, it was impossible to bring this name before the registration Committee. However, during the Canadian Medical Association meeting at Banff last June, in collaboration with Dr. J. Fenton Argue and Dr. Paterson, Dr. Campbell, as Registrar, assumed the responsibility of issuing an enabling certificate as it was necessary to be in the hands of the Registrar of the Medical Council, before his return to Winnipeg.

Motion:

Moved by Dr. T. Digby Wheeler, Seconded by Dr. Wm. Turnbull: "THAT Dr. Campbell's action in issuing an enabling certificate to Dr. Donald Hugh Paterson be confirmed." Carried.

2. Consideration of the Application for Registration of Dr. Saul Simon Berger.

Dr. Berger has a B.A. degree from the University of Saskatchewan in 1941; he received his M.D. degree from the University of Toronto in 1943, and was registered with the Medical Council of Canada the same year. A Basic Certificate accompanied his application.

Dr. Berger is at present about to be discharged from the armed forces, and may want to register in order to do some locum tenens work in the Province of Manitoba.

Motion:

Moved by Dr. T. D. Wheeler, Seconded by Dr. Wm. Turnbull: "THAT Dr. Saul Simon Berger's application for registration be accepted." Carried.

3. Consideration of the Application for Registration of Dr. Chieh Sung.

An application was received in April, 1946, from Dr. Sung. The letter was addressed from Idaho Falls, Idaho, U.S.A. Dr. Sung was asked to supply the necessary credentials before his application could be presented to the Registration Committee, for either an enabling certificate to write the examinations of the Medical Council of Canada, or to write the licensing examination of the Province of Manitoba. He had at no time submitted ony of the requirements, but in further letters insisted that he should be given an enabling certificate. In no instance does he even mention from what school he graduated in medicine. No action was taken by the Registration Committee.

4. Consideration of the Application for an Enabling Certificate From Dr. Yih Ping Chen.

A letter was received from Dr. Chen from Mexico, dated May 15, 1946, asking for an enabling certificate to write the examinations of the Medical Council of Canada. He enclosed a number of photostatic copies of certificates from different medical schools in China, none of which were of any particular value to the Registration Committee. It was decided that at present no action be taken as there are no credentials on which to base an opinion whether he should be allowed an enabling certificate or not.

(Continued on Page 574)

Personal Notes and Social News

Dr. and Mrs. M. R. MacCharles' daughter, Patricia, was married on September 23rd, 1946, at Knox United church, to Dr. Denton H. Booth, son of Mr. G. H. Booth and the late Mrs. Booth, of Norwood. Following their honeymoon, Dr. and Mrs. Booth will reside at The Pas, Man.

♦

Dr. and Mrs. W. R. Rennie are happy to announce the birth of a son at the Winnipeg General hospital on September 22nd, 1946.

♦

Dr. and Mrs. P. H. McNulty announce the engagement of their eldest daughter, Patricia Marie, to Ernest Frederick Hutchings, Jr., eldest son of Mr. and Mrs. E. F. Hutchings. The wedding to take place October 8th, 1946, at St. Ignatius Chapel.

♦

Dr. and Mrs. C. J. W. Dick, of Hodgson, Man., are receiving congratulations on the birth of a son, James Herbert Garth, on September 19th, 1946, at the Winnipeg General hospital.

♦

The Executive and Members of this Association wish to express their deepest sympathy to Dr. M. R. MacCharles on the loss of his father, Dr. R. W. MacCharles, who died on September 16th at the age of 88.

♦

Dr. and Mrs. E. W. Pickard take pleasure in announcing the birth of their daughter, Susan Mary, on September 2nd, 1946, at the Winnipeg General hospital.

♦

Dr. E. L. Ross, medical director of the Sanatorium Board of Manitoba has been transfered from Ninette to Winnipeg. He has been relieved of the superintendancy of the Manitoba Sanatorium at Ninette so as to able to devote his full time to the co-ordination of the board's widespread activities.

Dr. F. Sediak, formerly of Oak River, Man., is now located at Elie, Man., as Municipal Physician for the R.M. of Cartier.

♦

Dr. W. A. Shaver, formerly with the R.C.A.M.C., has now entered civilian practice at Rossburn, Man.

♦

Dr. I. H. Mazer has left Winnipeg for Herbert, Sask., where he will practice in the future.

♦

Dr. James Warren Whiteford, only son of Mr. and Mrs. Carman Whiteford, of Harmsworth, Man., was married on August 31st, at Wallace United church, Virden, Man., to Elizabeth Tyrie Moyes, second daughter of Mr. and Mrs. David Y. Thomson, of Victoria, B.C.

♦

Dr. Bryan R. Bird, formerly with the Psychopathic hospital, Winnipeg, has left for Toronto where he has joined the staff of the National Committee for Mental Hygiene.

♦

Gold Tournament Results

The winner of the Manitoba Medical Association Trophy for this year was Dr. Norman Warner with a net score of 72.

This year's tournament was played over the Elmhurst links on the afternoon of September 26th. The day started off with clear, blue skies and a bright, warm sun and the enthusiasts were overjoyed at the prospects, the first in three years, of ideal golfing weather. Disappointment was in the offing, however, for hiding behind the South-east hills of Elmhurst was old Jupiter Pluvius loaded to the gunwales and silently waiting until the players were well away from the clubhouse to give them everything he had in his reservoir. The following are the scores of the winner and the four runners-up:

	Gross	H.C.	Net
Dr. N. Warner	87	15	72
Dr. J. F. Cruise	96	23	73
Dr. H. M. Edmison	103	23	77
Dr. H. F. Cameron	105	26	79
Dr. Geo. Brock	105	26	79

(Continued from Page 568)

Registration Committee

Winnipeg, Man., August 7, 1946

A meeting of the Registration Committee was held on Wednesday, August 7, 1946.

Present: Dr. T. D. Wheeler, Dr. Wm. Turnbull and Dr. W. G. Campbell.

1. Consideration of the Application for Registration of Dr. Robert Lee McFadden.

Dr. McFadden obtained his B.Sc. degree from the University of Manitoba in 1938. He completed his medical course at Queen's University in 1943, and registered with the Medical Council of Canada the same year. A Basic Science Certificate accompanied his application.

Motion:

Moved by Dr. Wm. Turnbull, Seconded by Dr. T. D. Wheeler: "THAT Dr. Robert Lee McFadden's application for registration be accepted." Carried.

2. Consideration of the Application for an Enabling Certificate From Dr. Halena Wior.

An application for an enabling certificate was received from Dr. Wior. In her application she states that she has a medical degree from the University of Paris and Montpellier (France) Thesis, under date of December, 1941. During 1939, 1940 and 1941 she interned at several hospitals. In 1942 was in charge of the pediatric services in a refugee camp in France. From March, 1943, to March, 1944, she attended a pediatric clinic at "Santa Cruz y San Pablo" Hospital in Barcelona, Spain. She came to Canada with her husband, also an M.D., in April, 1944. She interned at the Women's College Hospital, Toronto, for three months, and ten months at the Ottawa General Hospital. Certificates or references were supplied for all the above. From September, 1945, to May, 1946, she attended the University of Toronto School of Hygiene, doing a special post-graduate course in Public Health. There is no Diploma of Public Health supplied in her papers. Since the end of May, 1946, she has been employed in Public Health work with the Department of Public Health and Welfare in Manitoba, in charge of the Health Unit at Ste. Anne, Manitoba.

According to her statement and an enclosed letter, she had applied to the College of Physicians and Surgeons of Ontario for an enabling certificate under date of November 11, 1944. She was asked by the College of Physicians and Surgeons of Ontario to attend the final year of a medical school in an Ontario university approved by the Council. The letter states that she does not require to pass the examinations of the final year, but must present a certificate of attendance. Apparently Dr. Wior has not completed the requirements as outlined by the College of Physicians and Surgeons of Ontario.

Motion:

Moved by Dr. T. D. Wheeler, Seconded by Dr. Wm. Turnbull: "THAT according to the resolution passed by the College of Physicians and Surgeons of Manitoba, Dr. Halena Wior's application for an enabling certificate cannot be accepted, and that she be advised to complete her arrangements with the College of Physicians and Surgeons of Ontario as per the letter from the Registrar of that Province, dated November 11, 1944." Carried.

Obituary

Dr. R. W. MacCharles

Dr. R. W. MacCharles died in the Winnipeg General Hospital, on September 16, after a long illness.

Born in Cape Breton, N.S., 88 years ago, he graduated in medicine from Dalhousie University in 1891, and practised in Cypress River, Man., for two years, then moved to Manitou in 1895, and was there for thirty-two years. In 1927 he came to Winnipeg and practised until his retirement in 1941. He was an elder in the Presbyterian church and during his stay in Winnipeg was an active member of Chalmers United Church. He is survived by a daughter and two sons, one of whom is Dr. M. R. MacCharles, of Winnipeg.

Book Review

Common Cardiac Conditions is a 300-page book which stresses the recent advances in diagnosis and treatment of the types of heart disease commonly encountered in general practice. There are seventeen articles by twenty-four contributors and the whole is under the editorship of William G. Leaman. All varieties of heart disease are discussed — congenital, rheumatic, bacterial, hypertensive, coronary, luetic and pulmonary. There are also articles on the psychosomatic aspects of heart disease, on the arrhythmias and on the surgery of the heart. Kats and Kaplan write upon the meaning of the electrocardiogram and its value to the general practitioner. Leaman's contribution is on the treatment of congestive failure with special reference to the prolonged use of mercurial diuretics. There is also a presentation on the recent trends in the diagnosis and treatment of peripheral vascular diseases.

This symposium will put the practitioner au fait with the cardiology of today. Its practical value is much greater than the price ($2.00) suggests. It is Number I of Volume V of "Clinics" published by J. B. Lippincott Company at $2.00 per single copy or $12.00 per year.

Manitoba Medical Association Committee Reports

Report of Executive Committee

To the Executive and Members of
The Manitoba Medical Association:

1. During these times of suggested changes in our manner of Medical practice a great deal of work and planning devolves on committees formed by or from an executive committee. So it is in this instance that the Executive and the whole Association owe a debt of gratitude to the various committees whose reports will be presented shortly. Our sincere thanks are extended to these committees for their efforts and we would especially like to mention the Economics Committee, the Manitoba Medical Service members, the members on the Health Services Commission, the Workmen's Compensation Board Committee and the Editorial Committee. These few, among others, have carried to completion another year's activities of the Manitoba Medical Association. Because some of the smaller and less busy committees have not been mentioned by name, please do not think your services unimportant and, therefore, not needed; they are!

2. During the past year, nine regular meetings of the Executive were held and also one special meeting of the entire Association on March 13th - 14th, 1946. The regular meetings were held on the third Sunday of each month, with one exception. In January the meeting was held to concur with a visit of Dr. Wallace Wilson, Dr. A. E. Archer and Dr. T. C. Routley. At this meeting the Basic Science Act of Manitoba and the Bills to license Chiropractors and Osteopaths were fully discussed. A great deal of criticism and discussion took place but it was finally agreed that, according to the working and our interpretation of these Acts, the medical profession in Manitoba had done what was right and had protected to the highest degree the rights and privileges of the people of the Province.

3. Correspondence to Dr. F. D. White from a former graduate, now in China, Dr. Peter Mar, was read and enjoyed by all. As a result of Dr. Mar's letters, the Executive asked the Secretary to subscribe and send to Dr. Mar the C.M.A. Journal and the A M A. Journal and also back numbers of the Manitoba Medical Review.

4. The special meeting held in March was called especially to complete the Schedule of Fees, in particular that part relating to specialists. This meeting will, no doubt, be more fully reported on by both the Economics Committee report and the report of the Manitoba Medical Service. About a day was spent reporting on and discussing the Health Services Act and the deliberations of Dr. Hollenberg's committee dealing with contracts.

5. A report from a committee appointed to study and act on the procuring of a full-time paid Secretary was given, and, after full discussion, it was agreed by resolution that, in order to carry on the business of the Association, the annual dues would have to be raised from the present fee to somewhere between twenty-five and seventy-five dollars.

6. Following the special meeting a complimentary dinner and entertainment was provided for Medical Officers of all the Armed Forces of this district. The dinner was sponsored by the Winnipeg Medical Society and the Manitoba Medical Association.

7. At the Annual Meeting of 1944-45 two resolutions were adopted which appeared to involve changes in the Constitution and By-laws. These were Resolutions Nos. 10 and 11, dealing first with our nominee to the C.M.A. Executive, this resolution stating that our President should be our representative on the C.M.A. Executive. By interpreting the word "representative" to mean "nominee" no change is necessary in the Constitution. As this resolution was passed by the Annual Meeting it should be amended. Resolution No. 11, dealing with representation on the Executive from the Faculty of Medicine, is taken care of in Article 6 (a) of the Constitution and By-laws as interpreted by the Committee on Constitution and By-laws. This resolution was also passed by the Annual Meeting and, in order to keep addenda to a minimum, it is suggested that this same end can be gained by amending Resolution No. 11.

8. For a fuller understanding of the activities of the Executive during the past year you are referred to the reports to follow and the discussion taking place during the business sessions.

Respectfully submitted.

P. H. McNulty,
President.

D. L. Scott,
Secretary.

Report of the Honorary Treasurer

To the President and Executive of
The Manitoba Medical Association:

9. Herewith certified financial statement from our auditors, Messrs. Rankin, Saul and Thornton.

All of which is respectfully submitted.

A. M. Goodwin,
Honorary Treasurer.

Winnipeg, Manitoba,
10th September, 1946.

To the Members,
Manitoba Medical Association,
Winnipeg, Manitoba.

Dear Sirs:

We have completed our audit of the books and accounts of your Association for the period from 1st September, 1945, to 31st August, 1946, and submit herewith the following relative financial statements:

EXHIBITS:

"A" Statement of Assets and Liabilities as at 31st August, 1946.

"B" Statement of Revenue and Expenditure from 1st September, 1945, to 31st August, 1946.

"C" Committee on Sociology:
Statement of Assets as at 31st August, 1946, and Statement of Revenue and Expenditure for the period ended that date.

The excess of Expenditure over Revenue, as set forth in Exhibit "B," amounted to $502.67. Membership fees received are in accordance with duplicate receipts on file and were reconciled with the membership cards issued. Expenditures have been properly authorized and satisfactory vouchers were produced for our inspection.

We verified the bank balances by obtaining a certificate from the Bank of Montreal, subject to allowance for outstanding cheques as shown by the books.

The Bonds representing the investments were produced for our examination and we found them to be in order. There has been no change in this account during the year. The market value of the investments at the present time is $8,629.75; this represents an appreciation of $636.25 over cost. This does not include an appreciation of $71.00 in the investments pertaining to the Sociology Committee.

Accounts Receivable are collectible on behalf of The Review and are considered to be fully collectible.

The assets of the Sociology Committee were included in the verifications referred to in the foregoing comments.

It is our pleasure to report that we found the records in good order and all our requirements as auditors have been complied with.

Yours very truly,
RANKIN, SAUL & THORNTON,
Chartered Accountants.

Exhibit "A"

10. Statement of Assets and Liabilities As at 31st August, 1946

ASSETS

Cash:		
Petty Cash on Hand	$ 20.00	
Bank of Montreal	1,585.42	
		$ 1,605.42
Account Receivable:		
Review Advertisers	464.26	
Advance Expenses paid on Review	149.68	
College of Psysicians and Surgeons	18.95	
		632.89
Investments:		
Province of Manitoba — Par	Cost	
4%, 1947 — $1,000.00	$ 975.31	
4½%, 1956 — 2,000.00	1,957.12	
Canadian National Railway:		
5%, 1969 — 1,000.00	1,086.07	
Dominion of Canada:		
3%, 1952 — 2,000.00	1,975.00	
3%, 1957 — 1,000.00	1,000.00	
3%, 1959 — 500.00	500.00	
3%, 1963 — 500.00	500.00	
		7,993.50
		$10,231.81

LIABILITIES

Accounts Payable:		
Dr. J. C. Hossack—Honorarium, January to August, $50.00 per month		$ 400.00
Canadian Medical Procurement and Assignment Board		524.45
Surplus Account:		
Balance as at 31st August, 1945	$9,810.03	
Less: Excess of Expenditure over Revenue	502.67	
		9,307.36
		$10,231.81

Exhibit "B"

11. Statement of Revenue and Expenditures From 1st September, 1945, to 31st August, 1946

REVENUE

Fees Collected	$2,701.00
Interest on Bonds	301.91
Winnipeg Medical Society	455.00
Exhibitors Annual Meeting	475.00
Manitoba Medical Service	200.00
	$4,132.91

EXPENDITURE

General Expenses:		
Salaries:		
H. M. Brown	$1,500.00	
C. Allison	60.00	
Unemployment Insurance Stamps	14.04	
		$1,574.04
Dr. Hossack—Honorarium		600.00
Printing, Postage and Stationery		534.72
Rent		336.00
Advertising		217.59
Telephone		101.76
Audit Fees		100.00
E. S. Feldsted—Gold Medals and Tax		81.25
Miscellaneous		52.04
Bank Charges		20.66
Business Tax		20.06
Wreath	15.00	
Light	13.01	
Servicing Typewriter	9.00	
Bond on Treasurer	5.00	
		$3,680.13
Annual Meeting		347.50
Executive Luncheons		40.10
Special Meeting and Dinner		491.53
Travelling Expenses—Dr. D. L. Scott		76.32
		$4,635.58
Excess of Expenditure over Revenue for the period from 1st September, 1945, to 31st August, 1946		502.67
		$4,132.91

Exhibit "C"

Committee on Sociology

12. Statement of Assets As at 31st August, 1946

Investments:		
Dominion of Canada Bonds, 1951—3%		$2,000.00
Cash in Bank of Montreal:		
Balance as at 31st August, 1945	$ 421.01	
Add: Revenue for year	83.60	
		504.61
		$2,504.61

Statement of Revenue From 1st September, 1945, to 1st August, 1946

Interest on $2,000.00 Dominion of Canada Bonds at 3%	$ 60.00	
5% Deduction made from Relief Accounts paid to Doctors and received by Sociology Committee as follows:		
Municipality of East Kildonan	23.60	
Revenue for period		$ 83.60

Report of Committee on Economics

To the President and Executive of
The Manitoba Medical Association:

13. The Committee on Economics has taken an active interest in all the developments of the year, both Provincial and Dominion, which affect or will affect the economic interests of our profession. It is, therefore, possible that we will report our opinion upon matters with which other committees of our Association have been dealing, in order that you may have a correlated view of the whole economic development and the direction in which it is tending.

14. *The Committee on Economics of the C. M. A.:* This committee met last June in Banff prior to and during the meeting of General Council of the C.M.A. Its purpose was to review the economic changes that have developed in the last year in the various provinces and in the light of these changes to chart a course for the guidance of the individual divisions.

15. In the main, the C. M. A. committee endorsed our Contract for the Municipal Doctor (vida infra)—pointing out that, although municipal practice was not the ideal method of practice, it did fill a useful purpose in those areas where it was difficult to attract a practitioner because of terrain, settlement, or financial capacity. This method of practice was considered a stop-gap for the time being until a general settlement of health services to the people is reached through co-operation between the Provincial and Dominion government.

16. The C.M.A. Committee on Economics further pointed out that where the people of a province demand and ask for a prepayment scheme for the provision of medical care, the profession should initiate and direct it in such a way that the interests of those that receive and those that give the services are both safeguarded without the interference of lay middle men, either in the formation of or the running of the scheme.

17. *Advisory Commission of the Manitoba Health Services Act:* The Manitoba Health Services Act embodies the plan of our Provincial Government for the care of our people from the point of view of preventative, diagnostic and curative medicine. To assist the Minister of Health in the carrying out of his duties the Advisory Commission was created under the Act. It consists of a Chairman (lay) appointed by the Minister and 10 members — 5 doctors and 5 laymen. Of the 5 doctors, one is the Deputy Minister of Health, another is a member of the Medical School and 3 are nominated by the M.M.A. This Commission has spent much time in deliberation and our representatives on it have the onerous duty of watching for the interests of the profession and of guiding the laymen in those matters of wholly medical significance.

18. The Commission has almost completed the draft of the Contract for Municipal Doctors. The only questions which have not yet been settled are those of pensions and sickness insurance. The difficulties in the latter two issues are those of administration, i.e., a municipality with one doctor can hardly carry a pension scheme or sickness insurance scheme for one man. The ideal method would be for the province to provide these two coverages for all municipal doctors. But this is not acceptable as yet to the Executive of the M.M.A. because it would put the government in a position of some authority over these men. Some compromise should soon be reached on these points without the stigma of "State Medicine" being applied to the solution.

19. The final draft of the contract as agreed to so far includes:

1. Optimum number of people to be served 1,500 to 2,000.
2. One full month's vacation with pay after a full year's service.
3. Two weeks post-graduate study with pay—cumulation of not more than two such periods.
4. Privilege to attend all meetings of District Societies and of M.M.A. without deduction of pay.
5. Duties: General practice in office, home or local hospital, including normal obstetrics and outlet forceps; minor surgery (which includes simple uncomplicated fractures and all surgical procedures carrying a fee of $20.00 or less in the M.M.A. Fee Schedule).
   Tonsils and Adenoids shall be included in those contracts where at least $4,000.00 per annum is paid as a net salary.
   The duties shall *not* include:
   Surgery—other than above
   Dental extraction
   Drug or alcohol addiction
   Workmen's Compensation Board work
   Department of Veterans' Affairs work
   Venereal disease
   Insurance work
   Any services for the above must be paid for by the patient or the government or private agency requesting the work.
6. Salary: $3 600 00—net annual salary for new graduate;
   $3,800.00—net annual salary for graduate of one year;
   $4,000.00—net annual salary after two years from date of graduation.
   For doctors who are engaged at the minimum net salary of $4,000.00 per annum, there shall be an annual increase of $500.00 for four succeeding years until a net annual salary of $6,000.00 is attained.

20. The provisions of this contract shall only apply of necessity whenever a Municipal Contract is signed which requires the concurrence of the Department of Health. Whenever funds from the province are obtained by a municipality to implement the services of the general practitioner as a "Municipal Doctor" —then these funds will not be forthcoming unless the provisions of this contract are adhered to.

21. When our members are renewing existing contracts with municipalities we would advise them to sign only a contract which has the above provisions. If you have any difficulty the Chairman of this Committee will assist you.

22. The Commission has also approved regulations under which there will be available annual scholarship loans up to $750.00 for either undergraduates or graduates in medicine who will undertake to practice in areas designated by the Commission or Minister under the Health Services Act—for a period commensurate with the amount of the loan—probably one year's practice will cancel $750.00 of loan.

23. Your representatives on the Commission the past year have been Dr. F. G. McGuinness, Dr. H. S. Evans and Dr. A. Hollenberg. Dr. McGuinness' term expired this year and he has been replaced by Dr. P. H. McNulty.

24. *Arrangements with the Department of Veterans' Affairs (D.V.A.):* The C.M.A. Committee in its relations with the D.V.A. came to definite arrangements whereby veterans entitled to D.V.A. medical care (with certain exceptions, i.e., those receiving 15% pension or more and those veterans who have been under treatment by D.V.A. before discharge for a definite condition) could avail themselves of free choice of doctor for any illness after discharge from the Armed Services. It must be pointed out that the above arrangements must be lived up to, and our Advisory Committee locally and the C.M.A. committee must both be on guard to maintain free choice of doctor. At the meeting of General Council of the C.M.A. last summer, the Director of D.V.A., Dr. Warner, made this statement—"The contentious part of this scheme seems to be, what happens to the veteran in a city where we have a (D.V.A.) hospital? Up to date we have tried to co-operate with the C.M.A. I am not so sure that it is going to work. In Winnipeg, for example, should the veteran be forced to go to Deer Lodge or should he be allowed to go to some other hospital of his choice? I would like you to know that there is considerable pressure being brought to bear on me that, in a place where the D.V.A. has a hospital, the veteran should not be given free choice of doctor but should be obliged to go to the D.V.A. hospital."

"For the time being, the arrangement which has been agreed upon with the C.M.A. (the family doctor scheme) will be in effect, but I cannot promise that that will be the case continuously."

25. Only constant vigilance by our leaders in the C.M.A. will maintain the agreement reached. It is obvious that if a veteran may only go to D.V.A. hospitals, that there will no longer be free choice of doctor, and the members of this Association will be relegated to the position of "house callers" and the "messengers" for the D.V.A.

26. The members of this Association will be informed by our D.V.A. Committee how the original scale of fees agreed to has now been revised. Many fees have been lowered and many have been left out. The Committee on Economics deplores the fact that so many reasonable fees have been reduced, e.g., Appendectomy from $100.00 to $85.00 and, further, that X-Ray fees to general practitioners have been reduced, whereas those of the specialists in X-Ray have not been reduced.

27. *Schedule of Fees:* The Schedule of Fees adopted by this Association at its last General Meeting has now been printed and a revised edition has also been published. It is not yet perfect in its format and in its classification. This meeting should direct that this work be continued; and suggestions from the membership should be forwarded to this Committee for its consideration. There is much room for improvement and much correlation must be done in the various procedures listed before this Fee Schedule can be of use in a scheme such as the Manitoba Medical Service (M.M.S.).

28. *Manitoba Medical Service (M.M.S.):* The M.M.S. is our prepayment scheme for the provision of medical services to our people It is still limited in its coverage to wage deduction groups. The President of the M.M.S. will report more fully to this Association but this commitee must bring to the attention of the Association certain aspects of the scheme.

29. Following the direction to this Association at its last General Meeting the M.M.S. has raised its premiums to subscribers and has made other changes in income levels of subscribers which seemed reasonable in the light of the general conditions prevailing at present.

30. One thing stands out pre-eminently and that is that the best interests of the M.M.S. and its members would best be served by separation from our business agents, viz: the Manitoba Hospital Service Association (M.H.S.A.). The progress of the M.M.S., in the opinion of this committee, has been continuously retarded by the passive and active resistance of the M.H.S.A. They have vigorously fought our increase in premiums, while they have now come out with increases of their own for hospitalization. The M.H.S. has absorbed costs of laboratory work and X-Ray work which, if more beds had been available in hospitals, would have been borne by the M.H.S.A., but no consideration has been given to the M.M.S. for this service. Further, it is the opinion of this committee that the amount paid to the M.H.S.A. for its service to the M.M.S. has been unreasonably large and that, even when our joint auditor pointed this out, the M.H.S.A. has not been disposed to rectify these changes retroactively. There is only one solution and that is complete separation and the sooner this is consummated the better it will be for all concerned.

31. The limitation of costs of investigation and ancillary services and of costs of chronic illness (such as hyperthyroidism, menopause, anaemia, which in the eyes of some practitioners require more visits than in the eyes of others) would greatly help the fund to carry the load—but that should not be the concern of the M.M.S. It is not the regulation of practice. It would be on much sounder ground if it limited what it proposes to cover than to limit the practitioner in the investigations he proposes on the number of visits he considers necessary. It must now be admitted that no scheme can financially remain solvent if it does not in some way limit its financial obligations for subscribers. This last statement stands out as the one important beacon in the course of the M.M.S. if it is to save the profession from internal dissension and itself from bankruptcy.

32. *Workmens Compensation Board (W.C.B.):* Your committee on W.C.B. met several times and has presented to the Commissioner of the Board its request for re-negotiation of the position of practitioners and the Board on several questions which have become rather acute the last few years. One of the main proposals of your committee concerned the taxation of accounts. It was suggested that the Medical Board of Referees, who are nominated by this Association, should act in two capacities; one, as adjudicator for the Board on disease or injury and secondly, as a committee for taxation of all accounts where these have been reduced by the Medical Officer of the Board. For this latter service we proposed that the M.M.A. would pay—possibly out of its treasury or by a percentage deduction from all medical fees received from the W.C.B. We further proposed that this taxing committee shall be a "board of equity"—in which equity, rather than conforming to the schedule of fees and precedents, would be the guiding principle. Many other matters, e.g., consultations, payment for medical illness associated with injury, revision of schedule of fees, etc., were considered. These matters are reported to you as a matter of record only since the negotiations are still in progress.

33. *Paid Secretary:* A paid secretary, whose full time would be devoted to the interests of this Association, was agreed to at our last General Meeting. This committee feels that the general situation of the profession at this crucial time should not be the concern solely of those who can spare a little time from their active practice now and then. The numerous committees at work and the great problems which face us cannot be left to the haphazard attention of those that can spare the time and when they can spare it. A suitable man who will co-ordinate all this work and regulate it in the interests of our Association is now absolutely necessary.

34. *Annual Duess* At the last General Meeting it was decided that the annual dues of our Association and the C.M.A. shall be on a sliding scale from $25.00 to $75.00. This meeting must either change this to a flat fee applicable to all or, if a sliding fee is adhered to, then a committee must be appointed who will assess the fees according to the income of the members. This committee suggests that no member of the Association should sit in judgment on the income of another member. It should be possible to make a sliding fee according to the number of years in practice—or make a flat fee and request all those who feel that they can contribute more to do so.

35. *Miscellaneous:* During the year your committee has had many matters referred to it in which it negotiated for individual members with government authorities The coroner's position in Winnipeg was negotiated with the Provincial Government to the mutual satisfaction of both. Many doctors contemplating contract practice in rural districts were advised to their advanage by the Chairman of this committee.

All of which is respectfully submitted.

A. Hollenberg,
Chairman.

Report of Manitoba Medical Service

To the President and Executive of
The Manitoba Medical Associations

36. Since our interim report to the special meeting in February, we have been implementing your recommendations:

(1) The percentages of a group applying for enrollment have been raised, the object being to get a better average selection of risks.

(2) The premiums have been raised for the complete service contract. This is effective for new contracts, and for renewals, but not during the term of present contracts. For this reason the benefit of this change will be only gradually apparent.

(3) The complete exclusion of those persons above the income level of $1,800.00 and $2,400.00 from obtaining a contract was considered by our Board. It was decided to ask your Association if they would agree to raising the income level for married persons with children or dependents to $3,000 00. As your Executive did not meet in June the reply could not be obtained in time to institute this change along with the two preceding. This will be done in due course, and it is probably better policy not to make too many changes in the contract at the same time.

Looking back on the year's work and scrutinizing our present position, there are many problems still to be met and solved.

37. Our Medical Director and Business Manager spent considerable time dealing with the problem of "pre-existing conditions." The doctors co-operate exceedingly well in such cases, although there are a few who always rule in favor of the patient. We have instituted a simple questionnaire for the patient on enrollment which we hope will settle the problem of "pre-existing ailments" then, rather than after they have received medical attention for them.

38. The cost of laboratory procedures has been too great in proportion to the other services. The fees laid down in the schedule date back to the time when the doctor did all his own tests. Now the technician does them in most cases at a small fraction of the previous cost. We have placed a ceiling of $5.00 on laboratory tests to meet this situation.

39. The cost of office practice is still very high. The elaborate investigation of puzzling or difficult cases has always been considered necessary, and admittedly is expensive. For various reasons elaborate investigations are being carried out in what appear to be ordinary cases, and with some individuals and

groups this is done as a routine in all cases. We get accounts ranging from $40.00 to $85.00 for patients who simply come in for a check-up with some minor ailment such as pin-worms. These procedures may be advisable but we have a feeling that when all doctors are being paid out of the one fund there is an element of unfairness about it. Possibly the best solution would be to restrict the sale of B contracts (complete service) to those who have had an A contract (Hospital service only) for a period of one or two years. This is being considered.

40. The costs of administration are too high. We are negotiating with the Manitoba Hospital Service Association at present, and we feel that some major re-adjustment is necessary and will be made.

41. The medical fees have been paid on the basis of 65% for everybody for several months. This percentage should be adjusted upwards as our income improves for better selection of risks, higher premiums, and lower operating costs. The summer months, contrary to expectations, have been very expensive. A copy of our audited annual statement will be forwarded.

42. It is a pleasure to pay tribute to the work of the members of our Board. The Medical members attend well and are very generous with their help. The business men who devote much time and effort to our organization have our sincere gratitude. They are always punctual, attend practically every meeting both of the Board and of Committees, they give invaluable advice, and give us the attitude of the public to our problems. I would particularly like to mention Mr. Robert McKay, Mr. I. B. Richardson, Mr. E. A. Jones, Mr. Fred Ross, Mr. M. D. Grant and Mr. Holmes.

43. Our Medical Director, Dr. Moorhead, has done a difficult (and sometimes thankless) job in a most fair manner. Mr. A. G. Richardson, our Office Manager, has devoted himself to his work, and puts in more hours at it than most doctors. Our office staff has also been most faithful and several members work after hours on many occasions.

44. The Fee Assessment Committee includes at least one doctor who is not a member of the Board.

To these gentlemen I would say thank you for doing an unpopular job.

All of which is respectfully submitted.

M. R. MacCharles,
Chairman.

Report of Editorial Committee

To the President and Executive of
The Manitoba Medical Association:

The result of our efforts to improve the Review are, believe, sufficient evidence to make comment unnecessary.

45. During the year the Committee lost the services of Dr. Ross Mitchell whose connection with the Review began almost with the first volume. We are glad that the Association has seen fit to give Dr. Mitchell tangible evidence of their appreciation of this long service.

46. Added to the Committee were Dr. S. S. Peikoff and Dr. Wallace Grant. Dr. Peikoff has brought to his task a degree of industry and enthusiasm that has been most helpful. Dr. Grant has been responsible for reporting the activities at the General Hospital and has done an excellent job. Dr. Murray McLandress has helped us by sending some very acceptable reports from the Children's Hospital. We especially wish to thank Dr. Lund who has supplied very regularly the abstracts dealing with anaesthetics.

47. Plans are being laid which, when they mature, should result in a still more useful journal. We are still handicapped by shortage of paper and a prohibition to extend our circulation. When these barriers are removed we shall expand both in size and coverage.

48. Our sincere thanks are due to our contributors, several of whom have gone to considerable personal expense in illustrating their papers. We are grateful, also, to contributors beyond the confines of our province who were good enough to add the lustre of their names to our journal. While, for the present at least, nearly all the papers will be "home made' we hope to publish from time to time articles from authors who live in other provinces and countries.

49. We wish to express our thanks to Mr. Whitley, the business manager, and to Miss Helen Brown whose days are made busier, and are sometimes lengthened, by work in connection with the Review. Finally, we thank the advertisers who make the Review possible.

All of which is respectfully submitted.

J. C. Hossack,
Chairman.

Report of Workmen's Compensation Board Committee

To the President and Executive of
The Manitoba Medical Association:

The following report covers the period of 1st January to 31st August, 1946. It will be recalled that the undersigned was appointed as of 1st January, 1946.

50. *Meetings of the Committee:* During the period under consideration a total of 22 meetings were held. Of these 2 were of a special nature, dealing with problems in ophthalmology. The remaining 20 are broken down as follows:

Month	No. of Meetings	No. of Cases Reviewed
January	2	6
February	3	10
March	3	9
April	2	7
May	2	6
June	3	9
July	2	6
August	3	9
Totals	20	62

51. *General Considerations:* No particular difficulties were encountered by your Committee, apart from those inherent in the matter of adjudication.

As you may be aware, a medical opinion is prepared on each patient and this is forwarded to the Workmen's Compensation Board for their guidance. No statement is prepared for the doctor who may be actively interested in the patient. It may be that your Committee vetoes a line of treatment which he has suggested.

Your Committee on occasion endeavors to contact the patient's doctor and discuss the case with him. This method is not always satisfactory. It may be that the suggestion introduced into the last paragraph of this report may be of value.

52. *Review of Fees:* On several occasions your Committee was asked by the Chief Medical Officer to review and adjust the accounts submitted by members of the medical profession. This was always a most disagreeable task but the following comments are offered:

1. Of all the accounts reduced by the Board, only a small proportion were referred to your Committee.
2. We believe the chief reason for the variation in accounts submitted by the profession lies in the inadequacy of the fee schedule. Several points may be mentioned in this regard.
   (a) The fee quoted for treatment of a condition is considered by the Board, and we believe rightly, to include (where applicable) an operative procedure *plus* a reasonable amount of after care. But the fee schedule does not define a relevant period of time nor does it describe what constitutes normal or abnormal complications, which may or may not be charged for as such.

(b) No scale is laid down for the treatment of fractures by the open method.

(c) On several occasions, difficulties have arisen over the question of whether a sprain-fracture is to be charged for as a sprain or as a fracture.

(d) The profession on some occasions apply a rather free interpretation to their diagnostic terms, viz: a fracture of the internal malleolus is not (according to standard beliefs) a Pott's fracture and should not be charged for as such.

(e) The interpretation of "necessary change of dressings," is difficult. It has frequently been noted that doctors charge for 6 "necessary" dressings per week, but somehow it is seldom that one takes place on a Sunday.

(f) It is believed that the present scale of fees requires not only revision of the fees quoted, but the addition of fees for procedures not presently quoted and amendments of a nature referred to above.

(g) In a great many instances the doctors' bills are not based on the fee schedule currently adopted.

3. It is felt that some body other than the Standing Committee should deal with the revision of fees, leaving this Committee to deal solely with the professional problems of the patients brought forward for review.

53. *Conduct of the Medical Boards:* The question has been brought up as to the attendance of the patient's own doctor as a witness to the proceedings of the Medical Board. Your Committee approve of this suggestion in principle.

Respectfully submitted,

C. E. Corrigan,
Chairman.

Report of Committee on Constitution and By-laws

To the President and Executive of
The Manitoba Medical Association:

54. In accordance with the instructions of the Executive of the M.M.A., the Committee on Constitution and By-laws submits herewith proposals for the constitutional amendments that appear to be needed for the creation of the new position of Chairman of the Executive:

55. ARTICE 6 — *Executive Committee* (P. 3): Add to Section (a) another Section (b) to read: "At the joint meeting following the Annual Election, the members of the old and new Executive shall elect one of their number to act as Chairman of the Executive during the ensuing year."

56. ARTICLE 8 — *Duties of the President* (P. 5)

"The President shall be concerned with the broad general policies of the M.M.A. and he shall be responsible for them under the direction of the Executive."

He shall preside at the Annual and other full meetings of the M.M.A.

He shall attend the meetings of the Executive Committee.

He shall, in consultation with the Chairman of the Executive, appoint Committees when so directed by the Executive.

(The above is to replace Paragraphs 1 and 3 (P.5), the rest to remain unchanged.)

57. ARTICE 9 — *Duties of Executive Committee* (P. 6)

(to these add a fourth paragraph)

Acting under the Executive and the President, the *Chairman of the Executive* shall be the active administrative officer of the M.M.A.

He shall decide the agenda for the Executive Meetings.

He shall preside at the Executive Meetings at the will of the President.

He shall attend the meetings of the Standing Committees.

He shall be responsible for seeing that the work and reports of all committees are rendered when due.

He shall integrate all committee work and reports and prevent overlapping and incoherence.

He shall direct the activities of the paid officials of the M.M.A.

He shall consult the President and accept his direction upon all matters of general policy.

He shall take the initiative in selecting and recording, subject to approval by the Executive, those matters of general policy that should be classed as "Considered Decisions."

Respectfully submitted.

F. D. McKenty,
Chairman.

Report of Cancer Committee

To the President and Executive of
The Manitoba Medical Association:

I beg to make the following report on the activities of your Committee on Cancer for the past year:

58. No problems were referred to the Committee by the Association and the Committee did not meet as a Committee of the Manitoba Medical Association during the year. The members of your Committee acted as your representatives on the Board of the Cancer Relief and Research Institute. They attended all meetings of the Board of Trustees and took an active part in its functions. They also acted as members of the Medical Advisory Committee of the Institute.

59. During the past year there have been no changes in the policies or in the nature of the activities of the Institute, but there has been an appreciable intensification of some of their fields of work.

60. The Institute maintains an educational service aimed at having the public seek medical advice at the earliest possible moment following the appearance of potential cancer symptoms. The number of volunteer public groups participating in this work has risen steadily from 140 in 1941 to 310 in 1945, with a corresponding increase in the number of people contacted throughout the Province.

61. The Institute maintains a rural biopsy service which will give a biopsy report on any tissue sent in from a practitioner in rural Manitoba. The Institute prepares containers which are available without charge upon application. The tissue examination is made without charge and the report mailed to the physician. This service has been increasing steadily. In 1941 approximately 100 rural biopsies were examined; in 1945 something over 450 were examined. It is the hope of the Institute that the use of this service will become even more widespread.

62. The Institute continues to supply radium at no charge to any resident of rural Manitoba, and at a charge based on their ability to pay in the area of Greater Winnipeg. The demand for the radium has remained almost constant over the last three years, and its use has become largely confined to the Cervix.

63. The X-ray therapy service operated by the Institute in the Forlong Memorial Department immediately adjacent to the Winnipeg General Hospital now supplies X-ray therapy free to all residents of rural Manitoba and, as with radium, the charge for residents of Greater Winnipeg is based on the ability of the patient to pay. Use of this service has increased almost 20% during the past year.

64. Two years ago the Institute established a cancer follow-up service originally designed to follow up all patients receiving X-ray therapy from its own centre. The service has proven so valuable that it has been extended, and any physician who has a private cancer patient and wishes to utilize the follow-up service needs only to send in the name, and the required follow-up program will then be carried out by the Institute. The address for this follow-up service is c/o the Forlong Memorial Department.

65. The relations between the Board of the Institute and your members has proven cordial during the past year, and it is with very real regret that we have to report the passing of Mr.

R. G. Persse, for many years Chairman of the Board of the Institute.

All of which is respectfully submitted.

C. H. A. Walton,
Chairman.

Report of Committee on Maternal Welfare

To the President and Executive of
The Manitoba Medical Association:

There have been no communications received for the attention of this Committee during the past year.

68. The statistics on maternal deaths came to hand too late to be considered by the Committee as a whole. However, the preliminary figures show a slight lowering of the maternal mortality rate for 1945, the deaths from puerperal causes being 2.0 per thousand live births as compared with 3.1 for 1944.

69. The total number of maternal deaths was 33, and of these only 2 were due to abortion. The causes as listed were as follows:

Hemorrhage	9
Accidents of childbirth (laceration, rupture or trauma of pelvic organs and tissues)	6
Infection during labour and puerperium	5
Unspecified conditions	4
Toxaemias of pregnancy—1. Death prior to delivery	2
2. Puerperal toxaemia	2
Ectopic gestation	3
Abortion—1. Self-induced with infection	1
2. Self-induced without infection	1

Autopsy was performed in only seven of these cases.

70. I wish to acknowledge the co-operation of Miss L. E. Stewart, of the Department of Vital Statistics in providing these figures.

All of which is respectfully submitted.

Elinor F. E. Black,
Chairman.

Report of Legislative Committee

To the President and Executive of
The Manitoba Medical Association:

71. Several bills affecting the profession came before the Legislature since our last Annual Meeting, only one of which required serious consideration by your committee, namely, a Bill to License Naturopaths.

This Bill was introduced by a private member and the Government afforded it no support, but all members of the House reviewed it as individuals.

72. Your President and the Chairman and Secretary of this committee had several meetings with the Minister and Deputy Minister of Health and interviewed members of the House. It was evident that the House would pass the Bill, in the belief that the licensing of some fourteen Naturopaths would place them in the same category as the previously licensed Osteopaths and Chiropractors, so that from then on the Basic Sciences Act could take full effect in the Province and there would be no organized cults left to circumvent this Act. The Bill was passed.

We were assured by members of the House that no further cults would receive consideration of legislation which would be retroactive to the Basic Sciences Act.

73. Since the Basic Sciences Act has come into effect there have been no Chiropractors or Osteopaths apply for examination for licensure in Manitoba.

All of which is respectfully submitted.

R. W. Richardson,
Chairman.

Report of Editorial Board of C.M.A. Journal

To the President and Executive of
The Manitoba Medical Association:

Your Editorial Board of the C.M.A. Journal begs to report as follows:

76. The following Manitoba doctors have contributed to the C.M.A. Journal: J. D. and R. E. Beamish, C. H. A. Walton, J. P. George, A. Hollenberg, F. W. Jackson, L. A. Sigurdson, A. P. Guttman, I. McLaren Thompson, D. Swartz, T. C. Brereton, T. H. Williams, R. S. C. Corrigan, Bruce Chown, Ross Mitchell and E. S. James.

Manitoba notes have appeared regularly in the Journal and your chairman is a member of the Editorial Board of the Journal.

Respectfully submitted.

Ross Mitchell,
Chairman.

Report of Divisional Advisory Committee, M.D. 10, Canadian Medical Procurement and Assignment Board

To the President and Executive of
The Manitoba Medical Association:

74. After completion of four years of service your Divisional Advisory Board ceased to function as at March 31st, 1946. It is the feeling of all members of this Board that this Committee has served a very useful purpose in relation to its Central Board at Ottawa. The Central Board, in its closing Minutes, passed the following resolutions, which will be of interest to the members of the Manitoba Medical Association:

1. "That inasmuch as this Committee feels that the C.M.P.A.B. has been of tremendous value to the people of Canada, to the Medical Services of the Armed Forces, to the Department of National Health and Welfare, to the Department of Veterans' Affairs and to the medical and allied professions of Canada, and that its continuance or the creation of a similar body may prove to be a useful asset to the Dominion, it stands at the disposal of the government for the re-organization of such similar body when and as the Government or one of its Departments wishes it to be re-organized."
   (Passed to the appropriate Departments of Government.)
2. "That, recognizing the value to the Federal Government Medical Services during the wartime, of the work done by the C.M.P.B.A. in co-ordination with the work of such Government Departments, this committee would recommend that an inter-departmental co-ordinating committee to consider all matters relating to federal responsibilities in the health field be set up, with representation from appropriate Federal Government Departments and added advisers from the Canadian Medical Association, the Canadian Hospital Council and other appropriate national representatives."
   (Passed to the appropriate Departments of Government.)

Respectfully submitted,

F. G. McGuinness,
Chairman.

Report of Extra Mural Committee

To the President and Executive of
The Manitoba Medical Association:

78. The following is the report of the Extra Mural Committee for the past year. Speakers were arranged for the following meetings:

1. Northwest Medical Society—October 17th, 1945:
   Dr. John Hillsman ..... "War Surgery"
   Dr. Duncan Croll ..... "Fractures"
2. Brandon and District Medical Society—May 8th, 1946:
   Dr. P. H. McNulty
   Dr. J. M. McEachern "Coronary Artery Disease"
3. Northwest Medical Society—June 26th, 1946:
   Dr. J. L. Lamont
   Dr. F. W. Jackson
   Dr. J. W. Macleod "Gastro-intestinal Problems"

The co-operation of the above named speakers is gratefully acknowledged.

All of which is respectfully submitted.

H. Medovy,
Chairman.

Report of Committee on Historical Medicine and Necrology

To the President and Executive of
The Manitoba Medical Association:

Your committee on Historical Medicine and Necrology begs to report as follows:

75. The keen interest of the Editor of the Manitoba Medical Review, Dr. J. C. Hossack, in historical medicine is reflected in each issue of the Review.

An article on Maternity Hospitals of Greater Winnipeg from the first humble beginning in 1883 to the present date appeared in the May number of the Review.

The following physicians of Manitoba died within the year since our last Annual Meeting: R. J. Waugh, J. M. Leney, A. J. Macdonnell, J. N. Hutchinson, J. H. Hastings, W. H. Clark, A. W. Moody, E. J. Ryall, J. D. McEachern, A. A. Murray, W. R. Gorrell, William Rogers, O. C. Dorman, A. E. Medd, Frank Groff, T. W. Hamilton. Our province is the poorer for their passing.

Respectfully submitted.

Ross Mitchell,
Chairman.

Report of Committee on Archives

To the President and Executive of
The Manitoba Medical Association:

Your Committee on Archives begs to report as follows:

77. At a meeting of the Winnipeg Medical Society on April 26th, Major H. S. Atkinson, R.C.A.M.C., loaned to the Medical Museum in the Medical College three articles which he had collected in England. They were a mahogany portable medicine case of the mid-Victorian era, a brass phlebotomy set and a Chinese opium cooker in cloisonne enamel.

The suggestion is made that the Committee on Archives be merged with the Committee on Historical Medicine and Necrology.

Respectfully submitted.

Ross Mitchell,
Chairman.

Report of Committee on Credentials and Ethics

To the President and Executive of
The Manitoba Medical Association:

82. As no problem on Credentials or Ethics has been submitted to provincial committee during the past year there is nothing to report.

Respectfully submitted,

A. F. Menzies,
Chairman.

Report of Radio Committee

To the President and Executive of
The Manitoba Medical Association:

83. There is nothing to report on behalf of the Radio Committee for the past year.

Respectfully submitted,

C. W. Clark,
Chairman.

Report of Committee on Public Health

To the President and Executive of
The Manitoba Medical Association:

81. While there were several meetings last year between the Honourable, The Minister of Health, and the Executive of the Manitoba Medical Association or Committees from it, there has been no occasion, so far as I know, for any meetings of this Special Committee this year. I would, therefore, simply report no meetings held or occasion for a meeting.

Respectfully submitted,

J. R. Martin,
Chairman.

Report of Advisory Committee to Department of Veterans' Affairs, M.D. 10

To the President and Executive of
The Manitoba Medical Association:

79. In compliance with regulations agreed upon between the C.M.A. and the Department of Veterans' Affairs, a special committee was set up consisting of Doctors F. G. McGuinness, Chairman; C. E. Corrigan, C. H. A. Walton, A. F. Menzies and Norman L. Elvin, to act in an advisory capacity to the D.V.A. To date, this committee has not been called upon for advice.

Respectfully submitted.

F. G. McGuinness,
Chairman.

Report of Pharmaceutical Committee

To the President and Executive of
The Manitoba Medical Association:

80. The duties of the Committee were completed with the publication of the Physicians' Formulary.

Respectfully submitted.

J. C. Hossack,
Chairman.

Report of Committee on Medical Education

To the President and Executive of
The Manitoba Medical Association:

84. As Chairman of this Committee, I beg to inform you that, since no matters were referred to the Committee during the year, no meetings were held and there is nothing to report.

Respectfully submitted.

A. T. Mathers,
Chairman.

Report of the Membership Committee

To the President and Executive of
The Manitoba Medical Association:

66. I wish to present the following report to date:

There are 669 Doctors in the Province of Manitoba	473	Winnipeg	
	196	Rural	
386 Active paid-up Members	258	Winnipeg	
	128	Rural	
235 Complimentary Memberships granted to doctors demobilized from the Armed Services	185	Winnipeg	
	50	Rural	
8 Honourary Members			
2 Associate Members			
38 Doctors Membership Fees unpaid	22	Winnipeg	
	16	Rural	
669 Total			

This represents a total membership in the Manitoba Division of 94%.

67. In 1945, as at August 31st, 416 doctors in the Province were active paid-up members. To date this year, you will note that only 386 are active paid-up members. This is partially offset by the fact that 19 members who paid membership fees in 1945 have received complimentary membership in 1946.

Twenty-one members have been lost to us during the year, 13 having left the Province and 8 are deceased.

To date in 1946, 15 new members have been enrolled.

My sincere thanks is extended to all those members who worked to maintain our high percentage of membership in the Manitoba Division.

Respectfully submitted.

A. M. Goodwin,
Chairman.

Manitoba Medical Service

A constant source of irritation and annoyance to the public has existed ever since the formation of the Manitoba Hospital Service Association, and a new factor has been introduced by the establishment of the Manitoba Medical Service; and the medical profession is definitely at fault in each case.

The Manitoba Hospital Service Association will only pay hospital bills when the patient has been admitted for treatment; where he or she is sent in for diagnostic procedures alone, such as X-rays, laboratory, BMR's and EKG's, liability is refused. The profession has been sent circulars time and time again, but this has not succeeded in stopping it. Naturally the patient is annoyed, and shows it. He has been told by his doctor that these services were covered by his contract, and finds that they are not. Besides it is very unfair to your professional brethren who are earning their livelihood in providing such services. You would not like it, and you will like it still less if some of the money that should go to you is used for the upkeep of hospitals. The new factor is that it is conveyed to the patient that as it is a medical service, then the bill should be paid to those who render the service, that is the hospitals. Quite recently there has been a case of this where considerable expense was incurred for ancillary services; the patient paid the bill, and now wants to know who is going to refund it, and if it is not refunded then what value is there in membership of the two services. Think it over gentlemen, especially those of you who criticize the Manitoba Medical Service and its works. A case like this hurts the whole profession for the patients think they have been let down, and been sold a pup.

The fee scale recently promulgated by the Manitoba Medical Association has been accepted for adoption by the Manitoba Medical Service, but cannot be put into use until a number of inconsistencies have been removed, and several anomalies corrected. It would appear as if there had not been sufficient co-ordination between the groups or individuals who prepared it. As the Manitoba Medical Service has no power to alter it, and no wish to try to interpret certain items, which would certainly lead to contention, the Manitoba Medical Association has been invited to appoint one or more experts to undertake the task.

Meanwhile a very active Referee Board has laid down certain rulings for adoption, and it will help if you would keep this page for references. A ceiling of $5.00 has been placed on laboratory services. BMR's, X-rays and EKG's are not included in this category. The regular fee for urinalysis will be paid if made at the first office consultation, but repeats will not be paid for if a charge is also made for succeeding office visits. Please note that in the new scale there are two fees for urinalysis, and the particular type of service must be indicated.

In the case of multiple patients, from one family, receiving care or treatment either in office or home for the same disease, and at the same call will be paid for at the following rates. Two members, one and one-third fee, three members, one and one-half. Diathermy $2.00 for the first six treatments, and $1.00 each for the remainder. Proetz treatments $3.00 each. Multiple ligations of single superficial varicose veins $10.00 each. Injection with alcohol of trigeminal nerve $50.00. Anal fissure, operation and post-operative care $50.00. Ligation of radial artery $35.00. Fracture-dislocation $10.00 added to fee for fracture. No bills for post-operative care during the following month as from the day of discharge.

There are still many rulings to be laid down for services not to be found in the new Manitoba Medical fee scale, but they will be dealt with as they arise, since only a very small proportion of over six thousand monthly reports can be brought up for assessment. There are two very hard working committees. The Referee Board which deals only with the value of the doctor's services in any illness. The Executive Committee, in addition to many other duties, decides if the Manitoba Medical Service shall be liable for any account where it is obviously pre-existing, but where the significance of it may or may not be apparent to the patient.

The Referee Board consists of three members, one retiring automatically each month; two of the members are from the board, and one picked at random from the profession. Though it is not a rule this third member is not infrequently chosen because he has been critical of the Manitoba Medical Service and all its ways. I think that after three months he becomes an excellent missionary for he has certainly learned a great deal about the problems and difficulties.

For those who are making a serious study of Medical Insurance, I cannot recommend anything better than a report, a copy of which was recently sent to me from Washington. I see the name of Mr. I. S. Falk on it; he was the author of "Security Against Sickness," published I think about 1936. Whenever a doctor asked me for a good outline of the subject, I recommended that book. The report has about 180 pages, but less than a third are concerned with peculiarly medical problems, and an excellent index tells the doctor what to read.

Many of our problems appear in it, but are not necessarily solved. For instance under the head of "Payments to Clinics and Organized

Medical Groups" we find the following: "A well-organized medical group can usually provide service (medical and laboratory) at lower cost-per-service than is possible for the individual practitioner. The organized group, therefore, tends to give a larger volume of service to those whom it serves than does the individual practitioner. Fee-for-service payment to the organized group would operate to the relative economic advantage of the group, as a consequence of its lower unit costs and its larger volume of service (per physician or per patient)."

"Hence if groups are paid at the same per capita rates as apply to individual practitioners, the net income of the group will generally be a larger percentage of the gross payments for services. Fixed rates of payment, per capita, from the insurance funds will therefore yield higher net incomes to the practitioners in well-organized groups than to the individual practitioners."

I had a very good example recently of how this service might operate under government control; a request was made for an appendectomy on a man recently discharged from the army. I got in touch with the army doctor who had recently operated on his gall-blader; in private most of you would have removed the appendix, but authority had only been given for the gall-bladder operation.

E. S. Moorhead, M.B.

V.D. Statistics

Ottawa, Sept. 17—Over a thousand more cases of venereal disease were reported in Canada in the second quarter of this year than in the same period in 1945, the Hon. Dr. J. J. McCann, acting minister of National Health and Welfare, announced today.

"Although the most recent reports show a decline in new cases, venereal diseases continue among the top-ranking problems facing Canada today," Dr. McCann said. "Venereal disease can be eradicated. This year the federal government has set aside over $270,000 to combat the V.D. menace, but legislation, money and medical skill are not enough. To eliminate this scourge requires an enlightened community and wholehearted co-operation, not only on the health front but equally on the moral, welfare and legal sectors."

In the first six months of this year 21,933 cases of syphilis and gonorrhoea were reported. Of these 8,283 were syphilis and the remainder gonorrhoea.

The total number of cases in the April-June quarter was 10,235 as against 11,698 in the first three months of the year. For the April-June period of 1945 total new cases of all types of V.D. were 9,188.

Dr. B. D. B. Layton, chief of the venereal disease control division, Department of National Health and Welfare, explained that these statistics are provided by provincial health departments and compiled by the Dominion Bureau of Statistics. The latest figures are "encouraging," he said, but would not in any way modify the all-out effort to eradicate these infections.

The rate of syphilis for Canada has fallen from 147 per 100,000 population during the first quarter of 1946 to 125 per 100,000 in the April-June period. The rate of gonorrhoea per 100,000 has declined 11 per cent, from 236.8 to 210.8 per 100,000 population.

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Announcement of Van Meter Prize Award

The American Association for the Study of Goiter again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held in Atlanta, Georgia, April 3rd, 4th, 5th, 1947, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a type-written double spaced copy sent to the corresponding secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia, not later than January 1st, 1947. The committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association. This will not prevent its further publication, however, in any Journal selected by the author.

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Closing Date May 15, 1947

The $34,000 prize contest for physicians' art work on the subject of "Courage and Devotion Beyond the Call of Duty" will be judged at the Atlantic City Centennial Session of the A.M.A., at Atlantic City, June 9-13, 1947.

Art works on other subjects may also be submitted for the regular cups and medals.

For full information, write Dr. F. H. Redewill, Secretary, American Physicians' Art Association, Flood Building, San Francisco, Calif., or to the sponsor, Mead Johnson and Company, Evansville 21, Ind., U.S.A.

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1946 July 14 to Aug. 10	1946 June 16 to July 13	1945 July 15 to Aug. 11	1945 June 17 to July 14	TOTALS Jan. 1 to Aug. 10,'46	TOTALS Jan. 1 to Aug. 11,'45
Anterior Poliomyelitis	7	1	2	1	9	12
Chickenpox	52	144	80	242	850	1622
Diphtheria	7	10	18	11	115	183
Diphtheria Carriers	1	2	....	....	12	24
Dysentery—Amoebic	....	....	....	....	1	....
Dysentery—Bacillary	....	....	2	1	1	9
Erysipelas	3	3	1	4	49	34
Encephalitis	....	1	1	1	1	5
Influenza	4	4	5	2	162	141
Measles	229	575	20	53	1535	472
Measles—German	4	4	....	5	20	33
Meningococcal Meningitis	2	2	....	....	13	10
Mumps	69	137	53	133	1787	1190
Ophthalmia Neonatorum	....	....	....	....	....	....
Pneumonia—Lobar	3	4	3	8	104	96
Puerperal Fever	1	....	....	....	2	1
Scarlet Fever	17	54	33	40	412	484
Septic Sore Throat	4	3	1	2	27	17
Smallpox	....	....	....	....	....	....
Tetanus	....	....	2	....	1	2
Trachoma	1	....	4	....	2	4
Tuberculosis	82	56	56	60	602	410
Typhoid Fever	....	1	3	1	10	31
Typhoid Paratyphoid	....	1	....	2	1	5
Typhoid Carriers	....	....	....	....	2	2
Undulant Fever	....	1	2	1	13	11
Whooping Cough	9	19	6	9	192	224
Gonorrhoea	180	199	206	169	1494	1209
Syphilis	40	48	43	32	418	355
Diarrhoea and Enteritis, under 1 yr.	14	28	4	2	126	3

DISEASES (White Cases Only)	*732,000 Manitoba	*3,825,000 Ontario	*906,000 Saskatchewan	*2,972,000 Minnesota	*641,000 †North Dakota
*Approximate population.					
Anterior Poliomyelitis	7	67	1	902	....
Meningococcal Meningitis	2	4	....	9	....
Chickenpox	52	539	76		....
Diphtheria	7	22	1	13	....
Diphtheria Carriers	1	....	1	....	....
Diarrhoea and Enteritis under one year	14	....	....	....	....
Dysentery—Amoebic	....	1	7	6	....
Erysipelas	3	5	4	....	....
Influenza	4	5	....	....	....
Jaundice (infectious)	....	3	1	....	....
Leth. Enceph.	....	....	1	1	....
Measles	229	676	139	57	....
Measles—German	4	36	2	....	....
Malaria	....	1	....	....	....
Mumps	69	428	190	....	....
Pneumonia, Lobar	3	....	3	....	....
Puerperal Fever	1	....	....	....	....
Scarlet Fever	17	210	9	48	....
Septic Sore Throat	4	20	....	....	....
Tularaemia	....	....	....	1	....
Tuberculosis	82	222	43	21	....
Trachoma	1	....	1	....	....
Typhoid Fever	....	7	3	1	....
Typh. Para-Typhoid	....	1	....	....	....
Undulant Fever	....	5	....	12	....
Whooping Cough	9	231	....	57	....
Gonorrhoea	180	552	....	....	....
Syphilis	40	331	....	....	....

†Reports not received.

DEATHS FROM COMMUNICABLE DISEASES

For the Month of July, 1946

Urban—Cancer, 43; Influenza, 1; Lethargic Encephalitis, 1; Pneumonia Lobar, 2; Pneumonia (other forms), 1; Syphilis, 2; Tuberculosis, 14; Hodgkin's Disease, 1; Diarrhoea and Enteritis (under 2 years), 6; Disease of Tonsils and Pharynx, 1. Other deaths under 1 year, 18. Other deaths over 1 year, 149. Stillbirths, 11.

Rural—Cancer, 24; Influenza, 2; Lethargic Encephalitis, 1; Pneumonia Lobar, 4; Pneumonia (other forms), 6; Syphilis, 1; Tuberculosis, 11; Diarrhoea and Enteritis, 6. Other deaths under 1 year, 17. Other deaths over 1 year, 135. Stillbirths, 13.

Indians — Pneumonia (other forms), 3; Tuberculosis, 2; Whooping Cough, 1. Other deaths under 1 year, 2. Other deaths over 1 year, 3. Stillbirths, 3.

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No weekly reports have been received from North Dakota during this period so we cannot report their morbidity figures.

Anterior Poliomyelitis—Manitoba has been fortunate again this year in having no increase over our usual non-epidemic year rate. Minnesota has had over 2,000 cases up to September 7. Montreal in Canada is the only place with a high incidence.

Diphtheria is still being reported in too large numbers. It's grand weather for immunizing.

Diarrhoea and Enteritis under one year is a very definite problem this year as usual. Among the communicable diseases it is one of the greatest causes of death.

Doctors Returned to Civilian Practice from Armed Forces

The following doctors have been discharged from the services and are now back in practice.

Name	Address	Telephone
Adamson, Dr. Gilbert L.,	Winnipeg Clinic, Winnipeg	97 284
Adamson, Dr. J. D.,	Winnipeg General Hospital	87 681
Alexander, Dr. Walter,	214 Medical Arts Bldg., Wpg.	95 300
Allen, Dr. C. S.,	216 Panama Court, Winnipeg	41 185
Anderson, Dr. Julius,	185 Maryland St., Winnipeg	404 065
Austman, Dr. K. J.,	704 McArthur Bldg., Winnipeg	95 826
Avren, Dr. S. S.,	416 McKenzie St., Winnipeg	59 422
Barrie, Dr. J. G.,	11 Rosewarne Ave., St. Vital	204 643
Baldry, Dr. Geo. S.,	616 Medical Arts Bldg., Wpg.	94 980
Beamish, Dr. R. E.,	216 Medical Arts Bldg., Winnipeg	94 354
Beckstead, Dr. J. L.,	619 Arlington St., Winnipeg	36 272
Bellan, Dr. S.,	400 Aberdeen Ave., Winnipeg	54 679
Bell, Dr. P. G.,	Deer Lodge Hospital, Winnipeg	62 821
Bennett, Dr. Wm. J.,	12 Newhaven Apts., Winnipeg	33 772
Benoit, Dr. C. F.,	114 Claremont Ave., Norwood	202 470
Berger, Dr. M.,	428 Anderson Ave., Winnipeg	58 345
Berbrayer, Dr. Peter,	205 Boyd Bldg., Winnipeg	94 112
Berger, Dr. M.,	428 Anderson Ave., Winnipeg	
Black, Dr. Geo. M.,	325 Washington Ave., Winnipeg	503 054
Bleeks, Dr. Cherry K.,	105 Medical Arts, Bldg., Wpg.	93 273
Bottomley, Dr. H. W.,	Winnipeg Clinic, Winnipeg	97 284
Boyd, Dr. Wm. J.,	1012 Ingersoll St., Winnipeg	24 427
Brotman, Dr. E. H.,	1137 Portage Ave., Winnipeg	36 500
Brown, Dr. M. M.,	508 Medical Arts Bldg., Winnipeg	93 889
Bruce, Dr. J. D.,	20 Buckingham Apts., Winnipeg	96 780
Bruser, Dr. D. M.,	58 Noble Ave., Winnipeg	
Burch, Dr. J. E.,	Winnipeg Clinic, Winnipeg	97 284
Cadham, Dr. R. G.,	City Hall Winnipeg	849 122
Chestnut, Dr. H. W.,	25 Knappen Ave., Winnipeg	
Carleton, Dr. M.,	603 Boyd Bldg., Winnipeg	94 763
Clark, Dr. C. W.,	216 Medical Arts Bldg., Winnipeg	94 354
Colpitts, Dr. Grant E.,	602 Medical Arts Bldg., Wpg.	93 996
Cooper, Dr. Ross H.,	212 Medical Arts Bldg., Winnipeg	93 103
Corrigan, Dr. C. E.,	307 Waterloo St., Winnipeg	401 271
Cohen, Dr. Harvey,	153 Cathedral Ave., Winnipeg	56 007
Cohen, Dr. R.,	600 Boyd Bldg., Winnipeg	93 275
Coke, Dr. L. R.,	238 Spence St., Winnipeg	
Collins, Dr. D. R.,	Internes' Quarters, Winnipeg General Hospital, Winnipeg	87 681
Cram, Dr. J. B.,	409 Power Bldg., Winnipeg	95 165
Croll, Dr. L. D.,	661 Broadway, Winnipeg	72 138
Daniel, Dr. E.,	Winnipeg General Hosp., Winnipeg	87 681
Davies, Dr. H. L.,	613 Boyd Bldg.	
Davidson, Dr. Kenneth,	6 Medical Arts Bldg., Wpg.	95 683
Davidson, Dr. Allan M.	1293 Wolseley Ave., Winnipeg	33 822
Davidson, Dr. A. M.,	6 Medical Arts Bldg., Winnipeg	95 683
Decter, Dr. P. H.,	283 Magnus Ave., Winnipeg	59 183
Dennis, Dr. F. T.,	Deer Lodge Hospital, Winnipeg	64 861
Doupe, Dr. J.,	592 Stradbrooke Ave., Winnipeg	46 501
Downey, Dr. J. L.,	333 Bartlett Ave., Winnipeg	46 751
Drulak, Dr. Stephen,	965 Garfield St., Winnipeg	27 577
Easton, Dr. S.,	216-7 Curry Bldg , Winnipeg	26 477
Edwards, Dr. K. N.,	139 Girton Boulevard	Tuxedo, Man.
Elliott, Dr. M. R.,	140 Lawndale Ave., Norwood	204 394
Elvin, Dr. Norman L.,	314 Medical Arts Bldg., Wpg.	95 317
Eshoo, Dr. H.,	Misericordia Hospital, Winnipeg	37 035
Evoy, Dr. G. H.,	264 Edmonton St., Winnipeg	94 335
Fahrni, Dr. G. P.,	105 Medical Arts Bldg., Winnipeg	93 605
Fahrni, Dr. Gordon S.,	105 Medical Arts Bldg., Wpg.	93 273
Fairfield, Dr. G. C.		Portage la Prairie, Man.
Farr, Dr. John,	Winnipeg Clinic, Winnipeg	97 284
Feinstein, Dr. M. S.,	72 Harrow St., Winnipeg	46 001
Feldsted, Dr. E. T.,	Winnipeg Clinic, Winnipeg	97 284
Flett, Dr. R. O.,	203 Medical Arts Bldg., Winnipeg	92 934
Franks, Dr. Fred,	492 Mountain Ave., Winnipeg	
Fryer, Dr. A. I.,	5 Gloucester Apts., Winnipeg	30 576
Furman, Dr. M. J.,	463 Ash St., Winnipeg	403 505
Galloway, Dr. G. D.,	74 St. Mary's Rd., Norwood	

Name	Address	Telephone
Gemmell, Dr. J. P.,	Winnipeg Clinic, Winnipeg	97 284
Guenther, Dr. H.,	315 Nairn Ave., Winnipeg	504 086
Gordon, Dr. Athol R.,	505 Medical Arts Bldg., Wpg.	96 232
Govan, Dr. W. R.,	Abbott Clinic, 409 Power Bldg., Winnipeg	95 165
Green, Dr. P. T.,	201 Hampton St., St. James, Man.	61 622
Greenberg, Dr. L.,	901 Boyd Bldg., Winnipeg	95 205
Guest, Dr. W. C.,	151 Yale Ave., Winnipeg	
Hall, Dr. C. W.,	1328 Pembina Highway,	
Hamilton, Dr. Glen F.,	408 Medical Arts Bldg., Wpg.	93 846
Harvey, Dr. A. L.,	Victoria Hospital, Winnipeg	42 351
Hastings, Dr. D. J.,	634 Somerset Bldg., Winnipeg	98 727
Hayter, Dr. F. W.,	Deer Lodge Hospital, Winnipeg	64 861
Hart, Dr. W. J.,	185 Kelvin St., Winnipeg	
Helgason, Dr. R. E.	Glenboro, Man.	
Henneberg, Dr. C. C.,	302 Medical Arts Bldg., Wpg.	92 710
Hitesman, Dr. R. J.,	512 Medical Arts Bldg., Wpg.	94 808
Hillsman, Dr. J. A.,	308 Medical Arts Bldg., Winnipeg	97 329
Holland, Dr. T. E.,	203 Medical Arts Bldg., Winnipeg	96 948
Homik, Dr. A. M.,	612 Cathedral Ave., Winnipeg	
Houston, Dr. A. B.,	937 Warsaw Ave., Winnipeg	45 925
Hunter, Dr. H. B. M.,	Deer Lodge Hospital, Winnipeg	64 861
Huot, Dr. J. M.,	St. Boniface Sanatorium, St. Vital	201 191
Ireland, Dr. J. R.,	Deer Lodge Hospital, Winnipeg	64 861
Israels, Dr. S.,	701 Boyd Bldg., Winnipeg	97 223
Jacks, Dr. Q. D.,	410 Medical Arts Bldg., Winnipeg	95 309
Jauvoish, Dr. S.,	206 Boyd Bldg., Winnipeg	93 240
Jones, Dr. E. A.,	Ste. 5, 117 Bryce St., Winnipeg	43 283
Kasian, Dr. P.,	St. Joseph's Hospital, Winnipeg	57 211
Kiernan, Dr. M. K.,	Winnipeg Gen. Hosp., Winnipeg	87 681
Kilgour, Dr. J. M.,	Winnipeg Clinic, Winnipeg	97 284
Kippen, Dr. D. L.,	Winnipeg Clinic, Winnipeg	97 284
Klass, Dr. A. A.,	132 Matheson Ave., Winnipeg	55 022
Kobrinsky, Dr. Sam,	602 Medical Arts Bldg., Wpg.	95 875
Kobrinsky, Dr. Sydney,	505 Boyd Bldg., Winnipeg	93 912
Kobrinsky, Dr. M. T.,	968 Strathcona St., Winnipeg	71 498
Lander, Dr. H. A.,	551 College Ave., Winnipeg	55 110
Lazareck, Dr. T. L.,	616 Aberdeen Ave., Winnipeg	53 674
Leach, Dr. W, B.,	150 Alloway Ave., Winnipeg	71 921
Leishman, Dr. J. D.,	400 Power Bldg., Winnipeg	96 234
Lebbetter, Dr. T. A.,	Winnipeg Clinic, Winnipeg	97 284
Lerner, Dr. A. I.,	211 McIntyre Bldg., Winnipeg	96 961
Loadman, Dr. B. E.,	Ste. 14A Pullmer Apts., Wpg.	43 601
Lotimer, Dr. L. E.,	Winnipeg Clinic, Winnipeg	97 284
Lund, Dr. P. C.,	Deer Lodge Hospital, Winnipeg	62 821
Lyons, Dr. R.,	420 Niagara St., Winnipeg	404 009
MacDonald, Dr. Frank S.,	616 Med. Arts Bldg., Wpg.	92 800
MacDonnel, Dr. J. A. K. (lady),	Winnipeg Clinic	97 284
MacKinnon, Dr. W. B.,	661 Broadway, Winnipeg	72 138
Maclean, Dr. Ian S.,	Winnipeg Clinic, Winnipeg	97 284
MacLeod, Dr. J. W.,	Winnipeg Clinic, Winnipeg	97 284
Malkin, Dr. S.,	701 Boyd Bldg., Winnipeg	97 223
Malone, Dr. M. C.,	St. Boniface Hosp., St. Boniface	201 121
Margolis, Dr. J.,	1897 Portage Ave., St. James	
Martin, Dr. J. H.,	St. Boniface Hospital, St. Boniface, Man.	201 121
Marmar, Dr. M.,	265 Flora Ave., Winnipeg	55 131
Margolese. Dr. J.,	414 Boyd Bldg., Winnipeg	24 541
Mathewson, Dr. F. A. L.,	308 Med. Arts Bldg., Wpg.	94 942
Medovy, Dr. Harry,	401 Boyd Bldg., Winnipeg	93 849
Miller, Dr. I.,	St. Boniface Hosp., St. Boniface	201 121
Mitchell, Dr. J. R.,	Ste. 10 Fairhaven Apts., Winnipeg	72 187
Moffat, Dr. R. G.,	340 Borebank St., Winnipeg	404 192
Moir, Dr J. H.,	41 Springside Ave., St. Vital, Man.	205 543
Moore, Dr. C. H.,	116 Medical Arts Bldg., Winnipeg	97 706
McCulloch Dr. A. W.,	Deer Lodge Hosp., Winnipeg	64 861
McFadden, Dr. R. L.,	Winnipeg General Hosp., Wpg.	87 681
McFarlane, Dr. R. F.	Internes' Quarters, General Hospital, Winnipeg	87 681
McFetridge, Dr. W. J. M.,	104 Arlington St., Winnipeg	
McIntyre, Dr. Donald N. C.,	303 Med. Arts Bldg., Wpg.	92 639
McKenty, Dr. Jack,	121 Girton Blvd., Tuxedo, Man.	61 777
	Winnipeg	42 496

Name	Address	Telephone
Lehmann, Dr. M. J.,	St. Boniface, Hosp., St. Boniface	201 121
Letienne, Dr. Rene,	St. Boniface Hosp., St. Boniface	201 121
McKenty, Dr. J. Stewart,	514 Med. Arts Bldg., Wpg.	92 711
McKenty, Dr. V. J.,	205 Boyd Bldg., Winnipeg	94 112
McLandress, Dr. Murray,	Apt. "D" Brentwood Lodge,	
MacNeil, Dr. Robert. W.,	608 Medical Arts Bldg., Wpg.	96 539
McNicol, Dr. H. L.,	Deer Lodge Hospital, Winnipeg	62 82?
McPhail, Dr. D. M.,	St. Bon. Hosp., St. Boniface, Man.	201 121
McPhail, Dr. Ethel M.,	90 Roslyn Road, Winnipeg	
McTavish, Dr. Geo. B.,	206 Affleck Block, Winnipeg	98 620
Natsuk, Dr. A. W.,	75 Sherbrook St., Winnipeg	36 821
Neilson, Dr. Clive,	404 Medical Arts Bldg., Winnipeg	94 041
O'Neill, Dr. M. F. H.,	379 Overdale St., St. James	61 999
Orchard, Dr. S. A.,	St. Boniface Hosp., St. Boniface	201 121
Ostapovitch, Dr. W. H.,	Misericordia Hosp., Winnipeg	37 035
Perrin, Dr. M. B.,	Winnipeg Clinic, Winnipeg	97 284
Pickard, Dr. E. W.,	118 Lenore St., Winnipeg	
Pierce, Dr. M. M.,	354 Stella Ave., Winnipeg	54 134
Rabson, Dr. L. R.,	452 Ash St., Winnipeg	
Rafuse, Dr. E. R.,	320 Sherbrook St., Winnipeg	
Ramsay, Dr. F. G.,	378 Borebank St., Winnipeg	402 669
Ranosky, Dr. Michael,	535 Somerset Bldg., Winnipeg	95 819
Revell, Dr. D. G.,	Winnipeg General Hospital, Wpg.	87 681
Richardson, Dr. R. W.,	105 Medical Arts Bldg., Wpg.	93 273
Ridge, Dr. J. M.,	Clearwater Indian Hospital, The Pas, Man.	
Riley, Dr. H. W.,	Winnipeg Clinic, Winnipeg	97 284
Rodin, Dr. Max,	St. Joseph's Hospital, Winnipeg	57 211
Rose, Dr. J. E.,	Winnipeg Gen. Hosp., Winnipeg	87 681
Rosenfield, Dr. V. L.,	405 Avenue Bldg., Winnipeg	97 141
Rumball, Dr. A. C.,	Deer Lodge Hospital, Winnipeg	62 821
Rusen, Dr. S. D.,	399 Machray Ave., Winnipeg	58 474
Rutherford, Dr. W. G.,	695 Wolseley Ave., Winnipeg	33 569
Ryan, Dr. George H.,	Winnipeg Clinic, Winnipeg	97 284
Sandborn, Dr. B. S. E.,	Grace Hospital, Winnipeg	37 271
Scarrow, Dr. Hart G.,	Deer Lodge Hosp., Winnipeg	64 861
Schoemperlen, Dr. C. B.,	216 Medical Arts Bldg., Wpg.	94 354
Shaver, Dr. W. A.,	596 Spruce St., Winnipeg	
Smith, Dr. N. S. H.,	275 Duffield St., St. James	63 224
Smith, Dr. F. Hartley,	86 Tache Ave., Norwood, Man.	203 993
Sommerville, Dr. A. N.,	614 St. Mary's Rd., St. Vital	202 411
Sommerville, Dr. A. N.,	614 St. Mary's Rd., St. Vital	
Steindel, Dr. B.,	154 Spence St., Winnipeg	36 979
Stephens, Dr. Gordon M.,	635 Henderson Hy., Wpg.	503 965
Stephenson, Dr. Earl,	409 Power Bldg., Winnipeg	95 165
Stewart, Dr. D. B.,	30 Ferndale Ave., Norwood, Man.	205 298
Stuart, Dr. F. G.,	103 Medical Arts Bldg., Winnipeg	93 521
Swartz, Dr. David,	303 Medical Arts Bldg., Winnipeg	92 639
Swan, Dr. A. J.,	303 Medical Arts Bldg., Winnipeg	97 005
Swan, Dr. R. S.,	215 Medical Arts Bldg., Winnipeg	94 354
Tanner, Dr. A. R.,	310 Medical Arts Bldg., Winnipeg	95 946
Taylor, Dr. C. H.,	606 Boyd Bldg., Winnipeg	98 937
Taylor, Dr. J. R.,	Winnipeg Clinic, Winnipeg	97 284
Tisdale, Dr. Paul K.,	Deer Lodge Hospital, Winnipeg	62 821
Vann, Dr. E. K.,	200 Linwood St., St .James	61 503
Valsrub, Dr. Samuel,	310 Redwood Ave., Winnipeg	
Wakefield, Dr. G. E.,	Ste. 1, 270 Roslyn Rd., Winnipeg	44 889
Walton, Dr. C. H. A.,	Winnipeg Clinic, Winnipeg	97 284
Walton, Dr. Fred A.,	3 Locarno Apts., Winnipeg	45 719
Weselak, Dr. A. A. (lady),	246 Selkirk Ave., Winnipeg	
Whelpley, Dr. E. H.,	586 Ingersoll St., Winnipeg	39 061
White, Dr. O. J.,	Winnipeg General Hosp., Winnipeg	87 681
Whiteford, Dr. J. W.,	520 Medical Arts Bldg., Wpg.	92 920
Whitehead, Dr. Robt. G. D.,	91 Maryland St., Wpg.	
Willows, Dr. R. L.,	St. Boniface Hosp., St. Boniface	201 121
Wilt, Dr. J. C.,	Winnipeg Gen. Hosp., Winnipeg	87 681
Winram, Dr. R. G.,	Ste. 51 Roslyn Apts., Winnipeg	
Atkinson, Dr. H. S.	Portage la Prairie, Man.	
Brokovski, Dr. T. W.	Brandon, Man.	
Brook, Dr. Joseph	Beausejour, Man.	
Bissett, Dr. E. D. R.	Pine Falls, Man.	
Brownlee, Dr. T. I.	Russell, Man.	
Comrie, Dr. C. L.	Brandon, Man.	
Corbett, Dr. Connor A.	Crystal City, Man.	
Crawford, Dr. C. S.	The Pas, Man.	
Davidson, Dr. D. A.	Cartwright, Man.	
Dick, Dr. C. J. W.	Hodgson, Man.	
Edmison, Dr. J. N.,	Manitoba Sanatorium	Ninette, Man.
Eggertson, Dr. S. H. O.	Steinbach, Man.	
Fiddes, Dr. G. W. J.	Brandon, Man.	
Findlay, Dr. J. A.	Brandon, Man.	
Gendreau, Dr. L. P.,	Mental Hospital	Selkirk, Man.
Goldstein, Dr. P.	Benito, Man.	
Gyde, Dr. M. C.	St. Pierre, Man.	
Harris, Dr. R. S.	Virden, Man.	
Hawes, Dr. E. G.	Brandon, Man.	
Hebert, Dr. J. L.	Lorette, Man.	
Howden, Dr. W. A.	Neepawa, Man.	
Hudson, Dr. J. E.	Hamiota, Man.	
Hunt, Dr. D. W.	Whitemouth, Man.	
Jacobs, Dr. A. L.	The Pas, Man.	
Johannesson, Dr. T.	Gilbert Plains, Man.	
Junek, Dr. V. D.	St. Rose du Lac, Man.	
Knight, Dr. L. W.	Souris, Man.	
Large, Dr. W. A.	Roblin, Man.	
Maclean, Dr. A. D.	Elkhorn, Man.	
Lansdown, Dr. L. P.	Pine Falls, Man.	
Lippmann, Dr. H. H.	Beausejour, Man.	
Luginsky, Dr. S. M.	Beausejour, Man.	
Myers, Dr. R. F. M.	15 Clement Block, Brandon, Man.	
North, Dr. W. H. C.	Virden, Man.	
Pincock, Dr. J. G. A.	Oak River, Man.	
Rabson, Dr. L. R.,	27 Rothesay Apts., Winnipeg	73 930
Ritchie, Dr. W. G.	Dauphin, Man.	
Schulman, Dr. I.	Oak Lake, Man.	
Sharpe, Dr. V. J. H.	Brandon, Man	
Shier, Dr. L. R.	Pierson, Man.	
Sneath, Dr. I. W.	Pine Falls, Man.	
Solomon, Dr. Alex. E.	Emerson, Man.	
Thomas, Dr. C. M.	Portage la Prairie, Man.	